

State of Idaho

Idaho Commission on Aging

State Long-Term Care Ombudsman Program



## **LONG-TERM CARE OMBUDSMAN**

## **TRAINING AND RESOURCE MANUAL**

2019

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## **INTRODUCTION**

The Long-Term Care Ombudsman Program is created for the purpose of promoting, advocating, and ensuring the adequacy of care received, and the quality of life experienced, by residents of long-term care facilities across the United States, Puerto Rico and Guam. The program is authorized by the federal Older Americans Act (OAA), Title III and VII. Federal regulations were implemented in 2016 to further clarify duties (CFR 45 Parts 1321 and 1324). Idaho Code, Title 67, Chapter 50, the Idaho Administrative Procedures Act (IDAPA) 15.01.03 and the Idaho Long-Term Care Ombudsman Program Manual (Program Manual) reflect these regulatory requirements and guide the Idaho Ombudsman Program. Verification of training manual content can be found in these documents.

Operation of the program is a joint effort of the federal Administration for Community Living (ACL), the Idaho Commission on Aging (ICOA), Office of the Idaho State Long-Term Care Ombudsman (SLTCO), Idaho's Area Agencies on Aging (AAA), and Local Ombudsman Programs (LTCO) located within the Area Agencies.

The Idaho Long-Term Care Training and Resource Manual is a compilation of both nationally developed and state specific material intended for the orientation and training of both volunteer and paid Long-Term Care Ombudsmen. It is grounded in Long-Term Care Ombudsman values such as being resident directed. Training for new Ombudsmen must be a minimum of 30 hours and provided from this Ombudsman Training and Resource Manual/Curriculum, with an additional minimum of 6 hours in the field. The manual content is intended to put information at the fingertips of the trainer and offers flexibility as to what is presented to trainees depending on their level of previous knowledge and experience. It gives options for how information is delivered, to accommodate various learning styles and time constraints.

The National Long-Term Care Ombudsman Resource Center (NORC) provides valuable online tools and information that will be referenced throughout this manual.

Additional teaching tools that can be found here are:

- Adult Learning Techniques and Documents Related to Training;
- Additional Training Materials created by the Center that relate to communication, culture change, etc.;
- NORC Conference Calls/Webinars.

[https://ltcombudsman.org/omb\\_support/training/documents](https://ltcombudsman.org/omb_support/training/documents)

Trainers will be familiar with, and incorporate all Ombudsman laws, regulations, rules, and policies when training potential Ombudsman representatives.

## **MODULE 1**

### **A. History and Role of the Long-Term Care Ombudsman Program (LTCOP) – Located on the National Ombudsman Resource Center website:**

<https://sites.google.com/site/historyandroleofltcop/home>

(In the upper left corner of the screen click on Module 1 (History and Role of the long-term Care Ombudsman Program))

**Overview:** This national online module provides basic information about the purpose, history and unique aspects of the Long-Term Care Ombudsman Program from the federal perspective.

**Learning Objectives:** Participants will learn:

- Why the Long-Term Care Ombudsman Program was developed;
- Primary responsibilities of the long-term care ombudsman; and
- The unique aspect of the LTCOP.

#### **Contents:**

- ✓ How the Long-Term Care Ombudsman Program Began
- ✓ The LTCOP under the Older American Act
- ✓ Unique Aspects of the LTCOP
- ✓ Accountability
- ✓ Long-Term Care Ombudsman Program Associations
- ✓ National Long-Term Care Ombudsman Resource Center
- ✓ Why Ombudsman Stay with the Program
- ✓ Review Quiz (Note: Contact the SLTCO for participant quiz results)

*Duration: 2 hours*

## **B. Idaho Long-Term Care Ombudsman Program**

The Idaho Long-Term Care Ombudsman Program (LTCOP) began in 1972 as one of the original 9 Federal Ombudsman Pilot programs. In order to assist long-term care residents in the assertion of their civil and human rights, the Idaho Legislature specifically defined the powers and duties of Idaho's program in legislation that took effect in 1988. The powers of the ombudsman program are intended to emphasize the primary role of investigating and resolving complaints made by or on behalf of long-term care residents. Provisions in Idaho ombudsman laws include:

- access to long term care facilities;
- access to long term care residents;
- access to records concerning long term care residents;
- disclosure of records;
- immunity from liability;
- conflict of interest;
- independence of the ombudsman program;
- confidentiality of information.

Individuals, whether paid or volunteer must comply with the applicable policies and procedures listed in the Idaho Long-Term Care Ombudsman Program Manual. A brief delineation of various ombudsman roles follows:

- LTCO Intern: Individuals who are working on completing the requirements for ombudsman certification or working on special projects as designated by the supervising Local Ombudsman.
- LTCO Level 1: Individuals who have obtained certification by the State LTCO. These individuals make regular unannounced visits to residents and may provide presentations.
- LTCO Level 2: Individuals who have obtained certification by the State LTCO. They make regular unannounced visits to residents, may provide presentations and resolve complaints.

## 1. Idaho Ombudsman Requirements

### Definitions - Idaho Code:

Commission means the Idaho Commission on Aging. Its' vision is to provide services and supports that improve the quality of life for older Idahoans, and people with disabilities, so they can live independent, meaningful, and dignified lives within the community of their choice. IC 39-5302(3)

Long-term care facility means an assisted living home or skilled nursing home that is required to be licensed in Idaho. IDAPA 15.03.02

Office means the State Office of the Long-Term Care Ombudsman. The Office of the Ombudsman for the Elderly (Long Term Care Ombudsman) is established in the Idaho Commission on Aging. IC 67-5009

Older Persons means a resident who is 60 years of age or older. IC 67-5006(4)

Ombudsman means the State Long-Term Care Ombudsman hired under IC 67-5009 and any designated Local Ombudsman.

Idaho Commission on Aging Program Manual - Provides official regulations for the operation of all Senior Services Act (SSA) and Administration on Aging (AoA)/ Administration for Community Living (ACL) funded programs.

[www.aging.idaho.gov/Documents/ICOA\\_Program\\_Manual\\_20141028.pdf](http://www.aging.idaho.gov/Documents/ICOA_Program_Manual_20141028.pdf)

All representatives must comply with federal and state governing laws, regulations, and policies below:

- Older American Act Section 712 Ombudsman: <https://acl.gov/about-acl/authorizing-statutes/older-americans-act>
- 45 Code of Federal Regulations Parts 1321 and 1324:  
<https://www.govinfo.gov/content/pkg/CFR-2017-title45-vol4/xml/CFR-2017-title45-vol4-part1324.xml>
- Idaho Code Title 67, Chapter 50,  
<https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH50/SECT67-5009/>
- Idaho Administrative Rules Governing the Ombudsman Program 15.01.03  
<https://adminrules.idaho.gov/rules/current/15/150103.pdf>:
- ICOA Program Manual, Chapter 9  
<https://aging.idaho.gov/resources/icoa-administration/>

### A. Background Check

All individuals representing the Ombudsman program, whether paid or volunteer, must pass an FBI background check if they have lived in Idaho for less than 3 years and an Idaho State Police background check if they have lived in Idaho for more than 3 years.

### B. Volunteer Ombudsmen

Each local Ombudsman program may implement a volunteer program to assist in carrying out long-term care ombudsman duties. Unless granted a waiver by the SLTCO, each volunteer will successfully complete training requirements outlined in this manual.

Volunteers will:

1. Be assigned duties and monitored by the managing Local Ombudsman;
2. Consult the Local Ombudsman prior to taking action on behalf of the program;
3. Not provide services outside of the assigned area unless authorized by the SLTCO;
4. Participate in 20 hours of continuing education opportunities annually, arranged or approved by the managing Local Ombudsman.

Every effort will be made to consider extenuating circumstances and a waiver to the above requirements may be submitted, in writing, to the SLTCO. If inactive for more than six months, a new application must be submitted for consideration by the SLTCO.

The Local Ombudsman will provide an annual evaluation of each volunteer ombudsman. (See Idaho Long-Term Care Ombudsman Manual, 9.4.4)

### C. Conflict of Interest Screen

Each Ombudsman trainee whether paid or volunteer must be screened to ensure that no conflict of interest exists. (Please see Ombudsman Code of Federal Regulation 45 CFR 1324.21 and Idaho Long-Term Care



## Ombudsman Manual 9.8)

A conflict of interest exists when interests intrude upon, interfere with, or threaten to negate the ability of the Ombudsman to advocate without compromise on behalf of long-term care facility residents. The Ombudsman will have no conflict of interest which would interfere with performing the function of the position. (See Conflict of Interest Screening Form, Attachment A). Conflicts include but are not limited to:

1. Direct involvement in the licensing or certification of a long-term care facility;
2. Ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility;
3. Employment of an individual by, or participation in the management of, a long-term care facility in the service area or by the owner or operator of any long-term care facility in the service area;
4. Receipt of, or right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility;
5. Accepting gifts or gratuities of significant value from a long-term care facility or its management, a resident or a resident representative of a long-term care facility in which the Ombudsman or representative of the Office provides services (except where there is a personal relationship with a resident or resident representative which is separate from the individual's role as Ombudsman or representative of the Office);  
**NOTE:** An Ombudsman should adequately compensate a facility for food provided by the facility with the exception of sample portions of food tested as part of an investigative process.
6. Accepting money or any other consideration from anyone other than the Local Ombudsmen Office, or

an entity approved by the State Ombudsman, for the performance of an act in the regular course of the duties of the Ombudsman without State Ombudsman approval;

7. Serving as guardian, conservator or in another fiduciary or surrogate decision-making capacity for a resident of a long-term care facility in which the Ombudsman provides services;
8. Serving residents of a facility in which an immediate family member resides;
9. Provision of services with conflicting responsibilities while serving as a LTCO, such as Adult Protective Services; discharge planning; pre-admission screening or case management for long-term care residents;
10. Participating in activities which:
  - Negatively impact on the ability of the LTCO to serve residents, or
  - Are likely to create a perception that the LTCO's primary interest is other than as a resident advocate.

Each potential trainee will complete the State Ombudsman Conflict of Interest Declaration (See Attachment A). If a conflict exists and cannot be remedied, the applicant will not proceed. All Ombudsman representatives will complete a Conflict of Interest Declaration annually which will then be entered into the Ombudsman reporting system for review by the SLTCO. (See Idaho Long-Term Care Ombudsman Manual 9.8)

#### D. Certification

After successful completion of the training program the State Ombudsman may designate the trainee as an Assistant Ombudsman.

## **MODULE 2**

### **A. The Aging Process – Located online on the National Ombudsman Resource Center website:**

<https://sites.google.com/view/module-2-the-aging-process/home>

**Overview:** This module provides basic information about the processes that occur throughout life, particularly in the later years, that are considered normal aging. It also discusses common illnesses in later life and the effects of medications. Ombudsmen must be able to work with older individuals and avoid stereotypes. Ombudsmen should be alert to the difference between the effects of normal aging and the results of diseases that afflict some elderly persons.

**Learning Objectives:** At the conclusion of this module, participants will know:

- Normal age-related changes;
- Myths and stereotypes about aging;
- Myths and stereotypes about care;
- Common illnesses and treatments; and
- The role of LTCO when poor care practices are encountered.

#### **Contents:**

- ✓ What is Aging
- ✓ Biological Aspects of Aging
- ✓ Psychological Aspects of Aging
- ✓ Sociological Aspects of Aging
- ✓ Myths and Stereotypes
- ✓ Common Illnesses and Conditions Associated with Aging
- ✓ Drugs and Their Side Effects in the Elderly
- ✓ Review Quiz (Note: Contact the SLTCO for participant quiz results)

*Duration: 1.5 hours*

## **MODULE 3**

### **A. Resident Rights**

**Located on the National Ombudsman Resource Center website:**

<https://sites.google.com/view/module3residentsrights/home>

In the upper left corner of the screen click on Module 3 (Resident's Rights).

#### **Overview:**

As an ombudsman, you not only have an obligation to provide information about residents' rights, but also a further obligation to assist residents in exercising those rights. This module will provide an understanding of residents' rights and the roles of Long-term Care Ombudsmen in supporting residents in exercising their rights. It provides a way of thinking about residents' rights and an approach for ombudsman work regardless of the specific issue.

**Learning Objectives:** At the conclusion of this module, participants will know:

- The principles underlying residents' rights;
- Specific residents' rights provisions;
- How residents can be encouraged and supported in exercising their rights;
- The role of the LTCO.

**NOTE:** While the ombudsman process and approach is very much the same regardless of where a resident lives, the tools that are available in terms of law and regulation are not. Much of this module references federal law and regulation, but it is important to note that these laws and regulations are applicable only to nursing facilities that accept Medicaid or Medicare. There is no comparable federal law or regulation for adult residential care settings, such as assisted living facilities. You must rely solely on state law and regulation for adult residential care settings and for nursing homes that do not accept Medicaid or Medicare.

**Contents:**

- ✓ Empowerment
- ✓ Nursing Home Residents' Rights Under the Nursing Home Reform Law
- ✓ Summary Listing of Rights
- ✓ Discussion of Selected Rights
- ✓ Enforcement of Resident's Rights
- ✓ Strengthening Residents' Rights
- ✓ Resident Councils
- ✓ Family Councils
- ✓ Legal Protections: Decision-Making Mechanisms
- ✓ Additional Resources
- ✓ Review Quiz (Note: Contact the SLTCO for participant quiz results)

*Duration: 1.5 hours*

## 1. Idaho Specific Long-Term Care Resident Rights

**The primary focus of the ombudsman program is to ensure that all long-term care residents are treated with dignity and respect and are able to exercise their rights.**

Currently Idaho's nursing facilities are certified to accept Medicaid, Medicare or both, and are governed by the federal regulation that outlines the rights for residents.

Assisted living facilities are governed by state regulation only. In Idaho, resident rights are similar to those in nursing homes and can be found in Idaho Administrative Rule 16.03.22.550, Residential Care or Assisted Living Facilities in Idaho:

<https://adminrules.idaho.gov/rules/current/16/160322.pdf> (See Attachment B Resident Rights)

Each resident has the right to:

- A. Privacy with regard to accommodations, medical and other treatment, written and telephone communications, visits, and meetings of family and resident groups;
- B. Humane care and environment including the right to:
  - A diet that is consistent with any religious or health-related restrictions;
  - Refuse a restricted diet;
  - A safe and sanitary living environment;
- C. Be treated with dignity and respect, including the right to:
  - Be treated in a courteous manner;
  - Receive a response from the facility to any request of the resident within a reasonable time;
  - Be communicated with, orally or in writing, in a language they understand. If the resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate in a language familiar to the resident must

be available and implemented. There are many possible methods such as bilingual staff, electronic communication devices, family and friends to translate. The method implemented must assure the resident's right of confidentiality, if the resident desires.

D. Have personal possessions:

- Wear his own clothing;
- Determine his own dress or hair style;
- Retain and use his own personal property in his own living area so as to maintain individuality and personal dignity;
- Be provided a separate storage area in his own living area and at least one (1) locked cabinet or drawer for keeping personal property.

E. Personal funds:

- (Residents whose board and care is paid for by public assistance will retain, for their personal use, the difference between their total income and the applicable board and care allowance established by Department rules.)
- A facility must not require a resident to deposit his personal funds with the facility;
- Once the facility accepts the written authorization of the resident, it must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

F. Management of Personal Funds:

If authorized by the resident, the facility must manage personal funds and:

- Must provide a full and complete accounting of personal funds and maintain a written record of all financial transactions;
- Afford the resident reasonable access to such record;
- Upon death, must promptly convey the resident's personal funds to the individual administering the resident's estate.

**G. Access and Visitation:**

Each facility must permit:

- Immediate access to any resident by any representative of the Department, by the state ombudsman for the elderly or his designees, or by the resident's individual physician;
- Immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives;
- Immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident; and
- Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

**H. Employment:**

Each resident must have the right to refuse to perform services for the facility except as contracted for by the resident and the administrator of the facility. If the resident is hired by the facility to perform services as an employee of the facility, the wage paid to the resident must be consistent with state and federal law.

**I. Confidentiality including:**

1. Right to confidentiality of personal and clinical records.
2. Freedom from Abuse, Neglect, and Restraints. Each resident must have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical or chemical restraints.
3. Freedom of Religion. Each resident must have the right to practice the religion of his choice or to abstain from religious practice. Residents must also be free from the imposition of the religious practices of others.



J. Control and Receipt of Health-Related Services including the right to:

1. Retain the services of his own personal physician, dentist, and other health care professionals;
2. Select the pharmacy or pharmacist of his choice so long as it meets the statute and rules governing residential care or assisted living and the policies and procedures of the residential care or assisted living facility;
3. Confidentiality and privacy concerning his medical or dental condition and treatment;
4. Refuse medical services based on informed decision making; (Refusal of treatment does not relieve the facility of its obligations under this rule).
  - a. The facility must document the resident and his legal guardian have been informed of the consequences of the refusal;
  - b. The facility must document that the resident's physician or authorized provider has been notified of the resident's refusal.

K. Grievances:

1. Right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

L. Participate in Resident and Family Groups.

1. Each resident must have the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

M. Participate in other activities.

1. Each resident must have the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

**N. Examine survey results.**

1. Each resident must have the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Licensing and Certification Unit with respect to the facility and any plan of correction in effect with respect to the facility.

**O. Access by Advocates and Representatives.**

1. A residential care or assisted living facility must permit advocates and representatives of community legal services programs, whose purposes include rendering assistance without charge to residents, to have access to the facility at reasonable times in order to:
  - a. Visit, talk with, and make personal, social, and legal services available to all residents;
  - b. Inform residents of their rights and entitlements, and their corresponding obligations, under state, federal and local laws by distribution of educational materials and discussion in groups and with individuals;
  - c. Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance and social security benefits, and in all other matters in which residents are aggrieved, that may be provided individually, or in a group basis, and may include organizational activity, counseling and litigation;
  - d. Engage in all other methods of assisting, advising, and representing residents so as to extend to them the full enjoyment of their rights;
  - e. Communicate privately and without restrictions with any resident who consents to the communication;
  - f. Observe all common areas of the facility.

**P. Access by Protection and Advocacy System:**

1. A residential care or assisted living facility must permit advocates and representatives of the protection and advocacy system designated by the governor under 42 U.S.C. Section 15043 and 42 U.S.C. Section 10801 et seq., access to residents, facilities, and records in accordance with applicable federal statutes and regulations.

- Q. **Access by the Long-Term Care Ombudsman. A residential care or assisted living facility must permit advocates and representatives of the long-term care ombudsman program pursuant to 42 U.S.C. Section 3058, Section 67 5009, Idaho Code, and IDAPA 15.01.03, "Rules Governing the Ombudsman for the Elderly Program," access to residents, facilities and records in accordance with applicable federal and state law, rules, and regulations.**
- R. Transfer or discharge
1. Each resident has the right to be transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay. In non-emergency conditions, the resident must be given at least thirty (30) calendar days' notice of discharge. A resident has the right to appeal any involuntary discharge.
- S. Exercise rights as a citizen
1. This includes the right to be informed and to vote.
- T. Be informed of Advanced Directives
1. Right to be informed, in writing, regarding the formulation of an **advanced directive** as provided under Section 39-4510, Idaho Code.
- U. Notice of any fee change not less than thirty (30) days prior to the proposed effective date of the fee change, except:
1. When a resident needs additional care, services, or supplies, the facility must provide to the resident, the resident's legal guardian, or conservator written notice within five (5) days of any fee change taking place; and
  2. The resident, the resident's legal guardian, or conservator must be given the opportunity to agree to an amended negotiated service agreement. If the two parties do not reach an agreement on the proposed fee change, the facility is entitled to charge the changed rate after five (5) days have elapsed from the date of the facility's written notice.

## **MODULE 4**

### **A. Problem Solving Process – Investigation**

**Located on National Ombudsman Resource Center website:**

<https://sites.google.com/view/module4theproblemsolvingproces/home>

In the upper left corner of the screen click on Module 4 (The Problem Solving Process: Investigation).

#### **Overview:**

The first function of a Long-Term Care Ombudsman Program (LTCOP) listed in the federal Older American Act is to:

*Identify, investigate, and resolve complaints that are made by, or on behalf of, residents.....*

This online module focuses on the investigation process and skills used by Long-Term Care Ombudsmen (LTCO). Investigation is the foundation of resolving problems. Another module, “The Problem-Solving Process: Resolution,” discusses the process and skills LTCO use to implement necessary changes after an investigation.

As a LTCO how you approach identifying, investigating, and resolving complaints directly affects:

- Your relationship with residents and staff;
- Your ability to achieve the desired outcome;
- Future relationship with residents, families, and staff; and
- The reputation of the LTCOP.

#### **Learning Objectives:**

At the conclusion of this module, participants will know basic information about:

- The problem-solving process as a framework for dealing with concerns;
- The ombudsman role in investigations;
- The primary tools or components of an investigation;
- Fundamental skills and other factors that influence investigations; and
- The principles of documentation.

**Contents:**

- ✓ Ombudsman Approach to Problem Solving
  - ✓ Policy Considerations
  - ✓ Dilemmas in Receiving Complaints
  - ✓ Stage 1 – Intake, Investigation and Verification
  - ✓ Summary
  - ✓ Additional resources
  - ✓ Review Quiz (Note: Contact the SLTCO for participant quiz results)
- 
- ✓ *Duration: 2 hours*

## **MODULE 5**

### **A. Problem Solving Process – Resolution**

**Located on National Ombudsman Resource Center website:**

<https://sites.google.com/view/module5theproblemsolvingproces/home>

#### **Overview:**

This module is a sequel to “The Problem-Solving Process Investigation” module. It covers Stages 2 and 3 of the problem-solving process. The information gathered during intake and investigation is analyzed and used to plan a resolution strategy. The long-term care ombudsman (LTCO) then acts to resolve the problem. If these actions are skipped, the ombudsman risks being ineffective in resolution.

#### **Learning Objective:**

At the conclusion of this module, participants will know basic information about:

- The ombudsman role in resolving problems;
- How to use the information gained during the ombudsman investigation to plan resolution strategies;
- The primary ombudsman approaches in resolving problems;
- The ombudsman responsibilities for follow-up after a resolution strategy has been attempted.

#### **Contents:**

- ✓ Analysis and Planning
- ✓ Resolution
- ✓ The Three Steps of Resolution
- ✓ Community Resources and Support Systems
- ✓ What an Advocate Should Know
- ✓ Working to Change the System: The Larger LTCO Role
- ✓ Additional Resources
- ✓ Review Quiz (Note: Contact the SLTCO for participant quiz results)

*Duration: 2 hours*

## **MODULE 6**

### **A. Long-Term Care: Facilities, Regulations, and Finances**

#### **Overview:**

As an ombudsman you will need a general understanding of:

- The different types of long-term care facilities;
- What federal and state regulations require facilities to do;
- What happens if they don't meet the requirements;
- The primary sources of payment for long-term care.

**Learning Objectives:** At the conclusion of this module, participants will know basic information about:

- Types of services and settings;
- Types of facilities;
- Ownership and management of long-term care homes;
- Staff and departments in facilities;
- Long-term care finances;
- Statutes and regulations governing assisted living homes;
- Regulations governing nursing facilities
- The survey process.

#### **Contents:**

- ✓ Types of Services
- ✓ Types of Facilities
- ✓ Ownership and Management of Long-Term Care Homes
- ✓ Licensure and Certification
- ✓ Staff and Departments in Facilities
- ✓ Long-Term Care Finances
- ✓ Long-Term Care Insurance
- ✓ Statutes and Regulations
- ✓ Medicare and Medicaid Requirements
- ✓ The Survey Process

*Duration: 2 hours*

## 1. Idaho Specific Information – Types of Services<sup>1</sup>

Long-term care is a combination of health care and support services provided on a continuous basis because of a chronic condition (physical or mental disability). Much of long-term care is nonmedical; including services such as assistance with bathing, eating, dressing, and cooking. Older Americans, people with physical or mental disabilities, or people with mental illness, are the most common users of long-term care services.

- Home and Community-Based Services (HCBS):

**Medicaid Waiver Programs** - Idaho's Medicaid Program has developed programs that provide some home and community-based long-term care services outside of an institutional setting. These programs require a *waiver* from the federal government and are referred to as *Medicaid Waiver Programs*. In Idaho, the **Aged and Disabled** Medicaid waiver program exists under the State's agreement with the federal Center for Medicare and Medicaid Services (CMS).

**STARTED:** 2004

**PURPOSE:** To provide a cost-effective alternative to individuals at risk of becoming institutionalized

**PEOPLE SERVED:** Adults with physical disabilities and older adults

Below are Other Sources of HCBS Long Term Care Services<sup>2</sup>:

- Home Health Care – Some people receive long term care services through a home health agency. The services are provided on a visiting basis in an individual's home and may include: part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical; social services; medical supplies and appliances (other than drugs and biologicals); and personal care services. Some of this care is funded through Medicare, while the majority is paid through insurance or by the individual privately. Home Health agencies or providers are required to be licensed by the State.

<sup>1</sup>The excerpt was adapted from the Illinois Ombudsman Curriculum, the Georgia LTCO Training Manual, developed by the Leigh Anne Clark, and the Louisiana Ombudsman Training Manual, developed by Sara S. Hunt

<sup>2</sup> From the Georgia LTCO Training Manual, developed by Leigh Anne Clark.



Some of this care is funded through Medicare, while the majority is paid through insurance or by the individual privately. Home Health agencies or providers are required to be licensed by the State.

- Respite Care – Respite care or services are provided to relieve a caregiver for several hours or days to allow the caregiver to “refuel” or attend to other matters so he or she may continue with the care-giving role. There is a great demand for respite services. This is funded through the Idaho Commission on Aging.
- Hospice Care – Terminally ill patients and their families may receive hospice care, which includes nursing services, social services, and counseling to assist a patient and his or her family through life’s “last station.” The whole family is considered the unit of care, and care extends through their period of mourning. Hospice care may also be provided to individuals living in long term care facilities.

## **2. Idaho Specific Information - Types of Facilities**

- A. Residential and Assisted Living Facilities (AL) –Since there are no federal laws or regulations defining assisted living, each state decides whether to establish standards, require licensure, or provide oversight to this type of facility. In Idaho, assisted living is established and defined in Idaho Code (IC) 39-3305, and in Idaho Administrative Procedures Act (IDAPA) 16.03.22 <http://healthandwelfare.idaho.gov/Medical/LicensingCertification/StateOnlyPrograms/AssistedLiving/tabid/273/Default.aspx>

The individuals who live in AL are often isolated and, in many cases, more vulnerable than nursing home residents. ALs are not health care facilities. Compared to a nursing home, an AL is a less restrictive environment. Large ALs may not look very different from nursing homes. Some of the more home-like aspects of smaller ALs may not be present: a contrast with the public perception that AL is a home like setting. For example, large ALs may have a large common, multi-purpose room and a large

dining room, instead of smaller rooms closer to living rooms and kitchens/eating areas in individual homes.

PURPOSE: Provide a home-like environment for older persons and persons with a mental or physical disability who need assistance with the activities of daily living;

Allow adults with a physical or mental disability to become integrated into the community and to reach their highest level of functioning.

DEFINITION: A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals and lodging to three or more adults not related to the owner.

- B. Skilled Nursing Facilities (SNF) - Federal and state laws and regulations provide a consistent definition, requirements, and oversight process for skilled nursing facilities.

PURPOSE:

Provide for safe and adequate treatment of individuals needing twenty-four hour nursing care.

DEFINITION: An institution (or a distinct part of an institution) that provides to residents:

Skilled nursing care and related services:

- Rehabilitation services for injured, disabled, or sick persons
- Regular health-related care and services, available to them only through institutional facilities (not intended for those individuals with a primary diagnosis of mental disease)

- C. Certified Family Home - Idaho State regulations guide the operation of this type of living arrangement. (Idaho Code 39-35)

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateonlyPrograms/CertifiedFamilyHomes/tabid/396/Default.aspx>

PURPOSE:

- Provide a residential living arrangement, supervision and care that is not considered long term care for 2 or less individuals.

**DEFINITION:** A residential, home-like living environment for two or fewer adults who:

- Are not able to reside in their own home and;
- Require care, assistance in daily living, protection and security, supervision, personal assistance and encouragement toward independence.

### **3. Ownership and Management of Long-Term Care Facilities<sup>3</sup>**

Ownership and management of long-term care facilities is carried out by a variety of providers with an almost endless array of administrative and financial arrangements.

#### **A. Proprietary Ownership**

When a facility's income (or revenue) exceeds its expenses, it earns what is commonly called a profit. Proprietary long-term care facilities are in business to produce profits. Profits are either given to the owner(s) of a facility or are reinvested in the business. There are two basic forms of proprietary ownership:

1. *Individual or partnership* – Profits are funneled to individual owners or partners who are personally liable for a business's operation and debts and can be sued as individuals. Such ownership has several tax advantages. For instance, profits are taxed only as individual income and not also as corporate income. Furthermore, the business may serve its owners as a tax shelter.
2. *Corporate* – Corporate stockholders or members are not individually liable for the corporation and cannot be sued for its actions or debts. As individuals, though, they do not receive the tax advantages that benefit individual owners. In fact, corporation profits that are passed on to owners are taxed twice: first as corporation income, then as individual income. An owner may avoid double taxation by being paid a salary by the corporation for serving as an officer of the corporation or working for the business in another capacity. Such salaries are not taxed as corporate profits since they are a business expense. Instead, they are taxed solely as personal income.

<sup>3</sup>From the Louisiana Ombudsman Program Manual, developed by Sara S. Hunt

#### B. Non-Profit Organizations

Non-profit, long term care homes also produce profits, but these may not be legally distributed to individuals or groups for personal use. Instead, profits are returned to the general coffers of the organization. The primary financial goal of non-profit facilities is to increase their revenues. Many non-profit homes are sponsored by religious or charitable institutions.

#### C. Government Facilities

Other long-term care facilities are government operated. Such homes are administered by county, state, or federal governments. Government facilities' costs tend to be higher than those of non-profit facilities. Veterans' nursing homes are included in this category.

### 4. **Licensing Idaho Long-Term Care Facilities**

Idaho law requires all nursing homes and assisted living facilities to be licensed before they can operate as a business. The license can be revoked under certain conditions outlined in federal and state law. In addition to being licensed, *all nursing homes in Idaho* can be certified for participation in Medicare and/or Medicaid. This means that they receive money from the Medicaid and/or Medicare programs and agree to abide by the respective program requirements.

### 5. **Idaho Specific Staff and Departments in Facilities<sup>4</sup>**

#### A. Residential and Assisted Living Homes (AL)

1. *Staff* - Assisted living homes are philosophically intended to simulate a person's own home while providing twenty-four hour non-medical supervision. The staff in an assisted living home is generally not trained in, or oriented to, a medical model and the owner may be directly involved with the resident's care.

<sup>4</sup>From the Louisiana Ombudsman Program Manual, developed by Sara S. Hunt

Other workers may be involved in the care, and some may be certified nurse aides (CNAs). However, often the care workers are not certified, nor have they received specialized education or gerontology training. There must be staff *in the home* whenever a resident is there, twenty-four hours a day if necessary.

2. *Administration* -

a. *Governing body* – ALs operated by an association, corporation, or other entity may have a governing body responsible for setting policy, overseeing its implementation, and selecting and evaluating the performance of the administrator of the AL.

b. *Administrator* – The individual who is responsible for the daily and overall operation of the AL. Someone must be designated to act on the administrator's behalf for any period during which the administrator is absent. An administrator may be responsible for more than one facility as long as they are available to be on-site at the facility within two hours. (See IDAPA 16.0322.215 for additional information)

3. *Care Providers - Care providers and other employees* – An AL must employ the type and number of care providers and other employees necessary to operate the home in compliance with state requirements.

4. *Certified Medication Aides* - Before AL staff can assist residents with medications, they must complete a Idaho Board of Nursing approved medication assistance course.

5. *Services* - The home must provide meals, general supervision and activities. The resident or the resident's legal guardian signs a contract, referred to as an admission agreement that specifies the services that will be provided, (e.g. bathing, transportation, special diets, religious services, orientation therapy).

B. Skilled Nursing Facilities (SNF)

1. *Staff* - The staff in a skilled nursing facility may be assigned to various departments (e.g. nursing, housekeeping, dietary, etc.). Each department is responsible for contributing to the overall functioning of the facility. The size and composition of departments of each

facility is contingent upon its total size and the level of care provided. Therefore, there may be differences between two nursing facilities. The staff positions in most nursing homes are usually developed and named to comply with federal and state standards. Listed below are typical departments and staff positions.

2. *Administration*

- a. *Governing Body* – Has the overall responsibility for operation of the facility. The governing body may be called the "Board of Directors", "Trustees", or may simply be the owners of the facility. The governing body must meet periodically to set policies and to adopt and enforce rules and regulations for the health care and safety of residents.
- b. *Administrator* – The person in charge of the day-to-day management of a nursing home. The administrator is appointed by the governing body and must be licensed by the state.
- c. *Medical Director* – A physician employed by the facility to be responsible for overseeing the development of specific health-care policies for the facility.

C. Physician Services - *Attending Physician* – The medical care of every resident must be provided under the supervision of a physician. A physician assistant or nurse practitioner may provide medical care to a resident under the supervision of that resident's physician. Residents may choose their own physicians. Each facility must have a physician available to furnish necessary care in an emergency.

D. Nursing - *Director of Nurses (DON or DNS)* – Is primarily responsible for establishing policies and procedures for the nursing staff and for supervising the provision of all nursing care. Unless a waiver has been granted, facilities must designate an RN to serve as the director of nursing on a full-time basis. The Director of Nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

1. *Charge Nurses* – May be either RN's or licensed practical nurses (LPN's). They supervise the nursing care provided during their shifts, usually for

one particular section of the nursing home.

2. *Nursing Assistants* – Provide the majority of assistance with personal care for residents. These persons often make up a high percentage of the nursing staff. If certified, nursing assistants must complete a state-approved training and competency evaluation program prior to, or within, three months of employment in a nursing facility. They must receive a minimum of 124 hours of training and complete a competency evaluation within their first four months of employment, with a few specific exceptions. Any aide used by a facility on a temporary or part-time basis must be trained and competent.

States must maintain a registry of individuals who have met the training and competency requirements. The registry must also contain any official findings by the state of resident abuse, neglect, or misappropriation of property by the aide. Before using someone as a nurse aide, the facility must check with the State Registry and the registry of any other state the facility believes will have information about the aide. (ALs in Idaho are not required to employ certified nurse aids).

- E. Other Medical Care – A Consultant Pharmacist oversees the receiving, dispensing, and administration of drugs and biologicals (language from regulations) to meet the needs of each resident.
  - *Other Medical Personnel* – Includes physical, speech, and occupational therapists that may or may not be actual employees of the home.
- F. Social Services – A *Social Worker* or designee that provides medically related social services to attain or maintain the highest practicable psychosocial well-being of each resident. In facilities with more than 120 beds, this individual must be employed full-time and must be a licensed social worker.
  - *Resident Services Coordinator* – Facilities with fewer than 120 beds must also provide services to attain or maintain the highest practicable psychosocial well-being of each resident. This individual does not have to have a particular educational background.

- G. Activities - *Activities Director* – Is responsible for an on-going program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This person must be a qualified professional.
- H. Dietary - *Food Service Supervisor* – Is in charge of preparing meals and menus. If this person is not a qualified dietician, he/she must receive consultant services regularly from a person so qualified.
- I. Other Important Personnel
1. Director of maintenance
  2. Director of housekeeping
  3. Personnel director
  4. Medical records director
  5. Bookkeeper and/or business manager
  6. Volunteer coordinator
  7. Chaplain

It may be important for ombudsmen to request to see the organizational chart of the home visited in order to understand the administrative lines of authority, responsibility, and supervision. This will enable you to identify the appropriate persons when you need information from staff at a particular facility.

Criminal history and background checks are required for nursing home, assisted living staff and contractors that have direct access to residents as per Idaho Administrative Code (IDAPA 16.03.02.009.01 & 16.03.22.009.01).

## **6. Long-Term Care Finances<sup>5</sup>**

Who pays for long-term care? The increasing number of very old and frail persons, the rising costs of health care, and the availability of fewer family members to provide home care combine to make this question a major national concern. While long-term care may include adult day care, home

<sup>5</sup>Excerpted from the New Mexico Ombudsman Curriculum developed by Sara Hunt



health, and other non-institutional services, the focus of this discussion is on who pays for nursing home care.

The vast majority of persons you encounter in nursing homes will be on Medicaid. Other sources of payment will include private pay, Medicare, Veterans Administration, and in a few cases, private long-term care insurance.

**IMPORTANT**

*The information in this section is intended to give you a general understanding of the requirements, services, and appeals processes for the primary sources of payment for long-term care. It is not sufficient for you to advise individuals about their eligibility or services. It is always best to advise a consumer to directly contact the pertinent eligibility office if they have specific questions.*

**A. Medicaid**

Medicaid is a medical assistance program for low-income persons. It was established by Title XIX of the Social Security Act of 1965 and is often referred to as "TITLE XIX." It is a joint Federal – State program that reimburses providers for covered services to eligible persons.

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The Department of Health and Human Services (HHS) administers the program through the Centers for Medicare and Medicaid Services (CMS). CMS establishes general guidelines and monitors operation of the program by the states. Both state and federal funds are used in the

program, based on a percentage determined by each state's per capita income. States are given some flexibility in deciding what services are covered and who is eligible, so there are differences in Medicaid from state to state. Recipients of certain forms of public assistance automatically qualify for Medicaid benefits.

These include recipients of:

- Supplemental Security Income
- Aid to Families with Dependent Children
- Foster Care
- Refugee Assistance

#### 1. Eligibility<sup>6</sup>

To qualify for Medicaid services in assisted living (home and community based services waiver program) or for nursing home care under Medicaid, a person must be both *categorically* and *medically* eligible. *Medical eligibility* involves verifying that the recipient has a medical need for care and is appropriately classified as to level of care. Medical eligibility is determined by the Idaho Department of Health & Welfare Medicaid Office.

- a. *Categorical eligibility* is based primarily on income and resources (assets). The categorical requirements for eligibility listed below are for nursing home care. These may change for the waiver programs. The requirements for nursing home care are:
  - i. *Residency and Citizenship*: Applicants must meet minimum U.S. citizenship and Idaho residency requirements.
  - ii. *Age or Disability*: Recipients must be 65 or older, blind, or disabled. Disability is determined using Social Security criteria.
  - iii. *Continuity of Stay*: A resident must be continuously institutionalized in a medical setting (e.g. hospital or SNF) for 30 days. If eligible, Medicaid will pay for the first month retroactively.

<sup>6</sup>Excerpted from the Louisiana LTCOP Manual. More information can be found at:

[www.idaholegalaid.org/node/2042/your-health](http://www.idaholegalaid.org/node/2042/your-health)

- b. *Income* cannot exceed \$\_\_\_\_\_ per month for an individual (three times the SSI Federal Benefits Rate) or \$\_\_\_\_\_ per month for a couple if both are in the same nursing home. It is determined using gross income, before any deductions for such items as Medicare premiums. (These figures change every year and are based on the yearly cost of living adjustment of Social Security benefits).
  - i. Definition of Countable Income: Income includes, but is not limited to, retirement benefits from Social Security, Railroad Retirement, Veterans Administration, or private pensions; dividends; interest; annuity payments; and income from trusts.
  - ii. Exclusions: Exclusions from countable income include income tax refunds; the value of personal, medical or social services received; payments made under credit life or credit disability policies; and repayment of the principal of a bona fide loan. The income of a spouse or any other family member is NOT considered.
- c. *Resources* include cash or other assets that can be converted to cash to meet basic needs. Medicaid refers to these as countable resources. The limits on countable resources are \$2,000 for an individual, \$3000 for a couple. Certain items are normally excluded from consideration as countable resources. These exclusions include:
  - i. Home property: A resident's home property is excluded if:
  - ii. A spouse or dependent child lives there;
  - iii. An SSI eligible person is joint owner.
  - iv. Personal property and household belongings where no unusual item exists worth more than \$2,000 (e.g. musical instruments, coin collections, jewelry).
  - v. One vehicle if used for medical appointments or essential daily activities.
  - vi. Burial plot and a burial allowance up to \$1,500 per individual. The allowance may be met by: (A) funds designated for burial expenses; (B) a burial plan for any amount tied to an irrevocable contract that specifies the services and amounts to be expended; and (C) a life insurance policy with no cash surrender value. This

- vii. clause allows people to shelter up to \$1,500 per individual by declaring it as set aside for burial.
- viii. Excess property (property not excludable as home property) can be excluded if the equity is less than \$6,000 and a 6% rate of return is received through rental. This formula is often applied to rental property or a second home on which the resident owes money.
- d. *Penalty for Transfer of Assets*<sup>7</sup> - A person applying for Medicaid must disclose all financial transactions he or she was involved in during a set period of time -- frequently called the "look-back period." The state Medicaid agency then determines whether the Medicaid applicant transferred any assets for less than fair market value during this period. (Refer to your local Health & Welfare Office for more information).
- e. *Individual's Share and Personal Needs Allowance* - Once an individual is eligible for Medicaid, the eligibility worker will determine how much the individual must pay the nursing home for his/her share of the cost of care. Generally, all of the individual's income must be used to pay the facility except for a monthly personal needs allowance and any amount needed to pay for private health insurance, including Medicare premiums. There is also a personal needs allowance for assisted living residents on Medicaid.
- f. *Spousal Impoverishment* - The expense of nursing home care can rapidly deplete the lifetime savings of couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," leaving the spouse who is still living at home in the community with little or no income or resources. These provisions help ensure that this situation will not occur and that community spouses are able to live out their lives with independence and dignity.

<sup>7</sup>Excerpted from the Georgia LTCOP Manual, developed by Leigh Anne Clark. More information can be found at: [www.idaholegalaid.org/node/2042/your-health](http://www.idaholegalaid.org/node/2042/your-health)

Under the Medicaid spousal impoverishment provisions, a certain amount of the couple's combined resources is protected for the spouse living in the community. Depending on how much of his or her own income the community spouse actually has, a certain amount of income belonging to the spouse in the institution can also be set aside for the community spouse's use.

- g. *Appeals* - A Medicaid recipient must receive written notice of any decision or determination that affects eligibility or coverage.

This notice must include the reasons for the decision and an explanation of hearing rights. If a decision is unfavorable – eligibility is denied, benefits seem insufficient, the effective date is problematic, or the amount of the patient's liability seems too high – the recipient may request a hearing.

## B. Medicare

Medicare was established by Title XVIII of the Social Security Act and is sometimes referred to as "Title VIII.

Medicare is actually two programs: **Part A** covers hospital and related care; and **Part B**, covers physicians and other medical expenses. (Refer to

[www.medicare.gov/medicare-and-you/medicare-and-you.html](http://www.medicare.gov/medicare-and-you/medicare-and-you.html) for more detail). Both parts have deductible and coinsurance amounts that increase

annually and must be paid before Medicare will begin to pay. Medicare, like Medicaid, is administered by a number of agencies. The Social Security Administration handles eligibility determinations. The Centers for Medicare and Medicaid Services (CMS) governs administration of the programs, and private insurance companies under contract with the government handle actual claims and payments.

1. *Medicare Part A* - Contrary to what many people believe, Medicare covers very little nursing home care. Medicare only pays for 100 days in a skilled nursing facility. These days must be preceded by a

*Refer individuals with questions about Medicare, and Medigap insurance to the Senior Health Insurance Benefits Counseling Program*

*1-800-247-4422*

hospitalization of at least three days. The first 20 days are paid in full. Thereafter, the beneficiary must pay a daily co-payment which changes each year. A beneficiary has the right to appeal the denial of skilled care Medicare.

You may deal indirectly with Medicare when assisting a person admitted to the nursing home from a hospital. You may hear the term DRG. This stands for *Diagnostic Related Group*. This term relates to the Prospective Payment System by which hospitals are paid based on a pre-set rate per case or type of diagnosis. This system, designed to control costs and reward efficiency, has sometimes led to patients being discharged in a weaker, sicker state, thus requiring more care. Hence they move to a nursing home, rather than return to the community. This has been one factor, along with the overall aging of the population, in the shift in the character of nursing homes residents. They are generally older and sicker than they were several years ago.

The prospective payment system is monitored by a Quality Improvement Organization (QIO). QIOs are physician-sponsored organizations with the authority to perform utilization and quality review functions for Medicare. They are under contract with CMS to monitor the prospective payment system. They review diagnoses, appropriateness of admissions, and quality of care. A hospital's decision to deny admission or deny continued Medicare coverage can be appealed to the QIO.

2. *Medicare Part B* - Part B of Medicare is similar to a major medical insurance policy. Examples of Part B coverage are: the cost of physician services, related medical services, test and supplies. As with Part A, there are deductibles and co-payments. You are more likely to get questions about Part B because many residents, whose care is not paid for by Medicare, can use Medicare Part B to cover certain items or services regardless of primary payer. For example, physical therapy can be billed to Part B for both private pay and Medicaid residents.

Part B payments are based on an allowable charge (also called reasonable or approved charge). This is the amount set by the part B carrier for a specific service. The charges are based on a review of doctors' and suppliers' actual charges in an area during the previous year. Part B pays 80 percent of the allowable charge.

A term you will hear frequently when dealing with Part B is "assignment". If a provider does not agree to accept Medicare's allowable charge as payment in full, it is called a non-assigned claim. The beneficiary is responsible for any excess amount over the allowable charge, plus the 20 percent co-payment. With non-assigned claims, either the beneficiary or provider submits the claim to the Part B carrier. The carrier sends a check to the beneficiary, along with an explanation of benefits form.

If the provider agrees to accept the allowable charge as payment in full, he is "accepting assignment." Part B pays 80 percent of the allowable charge, but the beneficiary is responsible only for the 20 percent co-payment. The beneficiary is not responsible for any excess charges. The provider submits the claim directly to the carrier and the carrier pays the provider.

3. *Medicare Part C* - A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.
4. *Medicare Part D* - Part D Medicare provides seniors and people with disabilities with comprehensive prescription drug coverage.

Some Medicare benefits may vary based on policies and managed care programs. (Refer to individual programs for details).

5. *Medicare Appeals* - Very few Part B beneficiaries appeal decisions. When they do, however, more than half win. An appeal may be appropriate if a claim is denied or less is paid than expected, or if one feels errors were made or information was overlooked. Appeals can be made to the carrier by making a written request for review. If the carrier's decision is unfavorable, a formal hearing can be requested. Specific information about appealing Part A and Part B decisions is located at [www.medicare.gov/medicare-and-you/medicare-and-you.html](http://www.medicare.gov/medicare-and-you/medicare-and-you.html).

6. *Medicare Insurance Premium Assistance*

a. *Qualified Medicare Beneficiary Program*<sup>8</sup>

Congress has provided for Medicare costs of poor and near-poor senior citizens to be paid for by the Medicaid program. This Medicare "buy-in," called the Qualified Medicare Beneficiary (QMB) Program, provides that Medicaid programs pay the premiums, deductibles, and coinsurance for seniors with incomes below the poverty line. (Contact your local Health & Welfare office).

b. *Specified Low-Income Medicare Beneficiary Program*

The program, Specified Low-Income Medicare Beneficiary (SLMB), pays the monthly medical insurance (Medicare Part B) premium for low-income Medicare beneficiaries. This program augments the QMB program.

To qualify for the SLMB program, an individual must be eligible for the QMB program in all areas except income and may be retroactive for three calendar months. (Contact your local Idaho Health & Welfare office)

C. Veterans Benefits

The Veterans Administration (VA) Paid Community Nursing Home Care Program is a plan under which the VA will pay for up to six months of skilled/intermediate nursing home care following hospitalization for those veterans who qualify.

<sup>8</sup>Excerpted from the Louisiana LTCOP Manual, developed by Sara S. Hunt



Hospitalized veterans who no longer require hospital treatment are eligible. In general, in order to take part in the program, the veteran must not have sufficient funds to meet the cost of this care himself. The nursing homes that are under contract with the VA to participate in this program agree to provide full nursing home care, including medicine and drugs, for a daily rate approved by the VA.

- *Nursing Home Care After 6 Months* - If the veteran continues to require skilled/intermediate nursing home care, the veteran may remain in the nursing home for an additional period of time at the veteran's own expense. If the veteran does not have sufficient funds and is not eligible under Medicare, the state Medicaid program may be able to supplement the cost of nursing home care.
- 1. *What Happens if a Nursing Home Resident Needs Hospitalization?* If the veteran requires hospitalization during the period of nursing home care authorized at VA expense, he/she may be returned to the VA Medical Center upon the recommendation of the nursing home physician. If the veteran's hospital stay is a relatively brief one, the veteran may be returned to the nursing home to continue to receive care for the remainder of the original placement agreement.
- 2. *What Happens to a Veteran's Pension when Placed in a Nursing Home at VA Expense?* In general, veterans without dependents will have their pensions reduced during the period of nursing home care at VA expense. However, there will be no reduction in the basic pension paid to veterans with dependents. Benefits paid in addition to the basic pension (for example: Aid and Attendance) will be reduced during the period of skilled/intermediate nursing home care. (Refer to your local VA Service Officer).

D. Long-Term Care Insurance

As the demand for long-term care increases, insurance companies have begun to develop products that provide coverage for nursing homes and/or home health care. These policies are expected to account for an increasing percentage of long-term care financing. Most experts agree, however, that they will never become the major source of payment.

All of these policies are some form of "indemnity" policy, meaning they pay a set amount per day, week, or month of care. There are tremendous variations in policies as to level of care covered, exclusions for certain conditions, renewability, and deductibles. If you find a resident who has a problem with such a policy, the Commissioner of Insurance may be able to help. If you are asked to advise someone about buying long-term care insurance, urge them to compare several policies. The potential for abuse with this product is great. Unclear policy language and misleading marketing practices exist as they do with many insurance products.

## **7. Regulations Governing Assisted Living Homes**

### **A. Licensure**

The Idaho Department of Health and Welfare Division of Licensing and Certification, licenses and provides oversight of assisted living homes that provide care primarily to older persons who require assistance, people who have a physical disability or those who suffer from dementia, or are mentally ill.

Homes are required to be licensed if they are caring for three or more residents that are not related to the owner by blood or marriage. Standard licenses can be valid for a period of three years if no core deficiencies are found. Among other things, the licensing body has the authority to inspect assisted living homes to verify compliance with state law and rules. (Idaho Code 39-3301 and Idaho Administrative Procedures Act 16.03.22) More information on licensure can be found at: [www.healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx](http://www.healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx)

### **B. Enforcement**

Anyone who believes that statutes or regulations governing assisted living homes have been violated may file a complaint with the appropriate licensing agency. The licensing agency will investigate the complaint if the agency concludes that the complaint has merit. Licensing agencies investigating complaints in assisted living homes have complete access to

the home; all records relating to the operation of the home; all resident files; and the residents and employees of the home. A written report of the investigation will be prepared that summarizes the findings of the licensing agency and copies will be provided to the home and the complainant.

If applicable, the licensing agency may issue a notice of violation that orders the assisted living home to correct the violation within a specific time period. Assisted living homes are then required to file a report of compliance that demonstrates how the home will operate in compliance with the statutes and regulations.

#### C. Survey Process

More in-depth information regarding Idaho's statutes and regulations on the survey process can be obtained from:

<http://healthandwelfare.idaho.gov/Medical/LicensingCertification/StateOnlyPrograms/AssistedLiving/tabid/273/Default.aspx>

### 8. Regulations Governing Nursing Facilities

Who regulates nursing homes? If you asked this question of a nursing home administrator, the answer may be "everybody." Nursing homes are regulated at several levels: federal, state and local. In fact, one common criticism of the nursing home regulatory system is that the authority to make decisions is so spread out that it often seems that no one is accountable to make sure the system is working.

*The Long-Term Care  
Ombudsman Program has  
no enforcement authority  
over facilities.*

The federal and state levels are intricately tied together, primarily through contractual agreements. *Ombudsmen are to represent **residents**, not to see that facilities comply with requirements. In representing residents, ombudsmen must understand the regulatory system, work with facility personnel and enforcement personnel, and advocate for the system to address the needs of residents.*

#### A. Federal Level

The top federal agency that has responsibility for regulating nursing facilities is the U.S. Department of Health and Human Services (DHHS). Within DHHS, two sub-offices handle the responsibilities described above:

1. *The Office of Civil Rights (OCR)* enforces the federal civil rights laws. Examples of these laws that affect nursing home residents are provisions that prohibit discrimination on the basis of race, color, national origin, and handicap. OCR has ten regional offices.
2. *The Centers for Medicare and Medicaid Services (CMS)* manages and promulgates the regulations for the federal Medicare and Medicaid programs. To implement the Nursing Home Reform Amendments of OBRA '87, the Health Care Finance Administration (HCFA now CMS) developed the *Medicare and Medicaid Requirements for States and*
3. *Long-Term Care Facilities* that are part of the *Code of Federal Regulations*. These requirements interpret the law and define the standards of care that nursing facilities must meet.

Most of the federal responsibilities have been passed on to the state through contractual arrangements. For the most part, the appropriate federal agencies simply monitor the state agencies to determine whether they are adequately performing their responsibilities.

#### B. State Level

In Idaho, the Bureau of Facility Standards (BFS) within the Department of Health and Welfare Bureau of Long-Term Care, has the lead role in surveying and approving nursing homes to be providers under the Medicare and Medicaid programs. Staff from BFS conducts surveys in facilities to ensure that they are complying with the standards. Facilities with problems will be surveyed more frequently. If a complaint is lodged against a facility, a complaint survey will be conducted as needed and is in addition to the regular annual survey.

#### C. Local

The amount of local regulatory involvement in nursing facilities depends on local laws. These laws vary from city to city. It is common, however, for the sanitation department, the local health department, and sometimes

other local agencies to periodically review whether nursing facilities are complying with local laws.

**D. Medicare and Medicaid Requirements for Nursing Facilities**

As discussed earlier, CMS promulgated the *Medicare and Medicaid Requirements for States and Long-Term Care Facilities* to interpret the sweeping Nursing Home Reform Amendments of OBRA '87. The requirements, incumbent upon all facilities that elect to participate in Medicaid set forth broad standards and are divided into fifteen major categories:

- Resident Rights
- Admission, Transfer, and Discharge
- Resident Behavior and Facility Practice
- Quality of Life
- Resident Assessment
- Quality of Care
- Nursing Services
- Dietary Services
- Physician Services
- Specialized Rehabilitative Services
- Dental Services
- Pharmacy Services
- Infection Control
- Physical Environment
- Administration

Major revisions were again made in 2016 and rolled out in 3 phases (2016, 2017 and 2019). These revisions focus on care planning and person-centered care, admission, transfer, and discharge procedures, grievance procedures, resident rights, choice, safety, self-determination, staffing, medications, quality of care, and protection from abuse, neglect, and exploitation.

#### E. The Survey Process

The Bureau of Facility Standards (BFS) with the Idaho Department of Health and Welfare inspects, licenses, and certifies nursing homes in Idaho. Field staff document compliance with state and federal regulations through regular, unannounced surveys conducted no later than 15 months after the last day of the previous survey and through abbreviated surveys prompted by complaints. Life safety code surveys are also conducted. The survey process involves off-site preparation, and on-site evaluations of the care and services provided to residents in accordance with regulatory requirements. In the case of Medicare and Medicaid certified facilities, the standards are set by the Centers for Medicare and Medicaid Services (CMS).

During surveys, deficiencies may be cited if the facility fails to meet any of the requirements and will now be done electronically.

Each deficiency cited is assigned a scope and severity level (from A to L), which indicates the level of harm and the pervasiveness of the deficient practice. Level A means no actual harm and an isolated basis, while L means immediate jeopardy to resident health and safety on a widespread basis.

1. *Surveyors will complete seven tasks that comprise the standard survey:*
  - a. *Offsite preparation* - The objective is to analyze various sources of information in order to identify potential areas of concern and special features (e.g. special care units); identify potential residents to be included in samples; and to determine if concerns or features affect team composition. For example, potential problems with medications may indicate that a pharmacist be included on the team. The team looks at the Facility Quality Indicator (QI) Profile. The *ombudsman* is one source of information.
  - b. *Entrance conference/on-site preparatory activities* - The team coordinator meets with the administrator and introduces the team members. The coordinator also requests certain information about the facility and its population.

As part of these preparatory activities, notices will be posted alerting residents that the survey is being conducted and that surveyors are available to meet with residents. The team coordinator will also ask the resident council president to assist with the group interview and for permission to review the council minutes for the last three months.

- c. *Initial tour* - The objectives of the tour include evaluating the facility environment, potential problems, and selecting residents and family members for the interviews. During this tour, surveyors are directed to pay special attention to certain quality of life and care indicators (e.g. appropriateness of grooming, staff-resident interactions, activities, staff response to problematic resident behaviors, infection control procedures, and the facility's abuse prohibition policies).
- d. *Sample selection* - Sample size is based on census. The make-up of the sample is intended to reflect variation in case mix, identified concerns, resident characteristics, and special factors (e.g. new admission).
- e. *Information Gathering* - This task provides a systematic method for gathering the information necessary to determine compliance with requirements. It also provides the information for determinations made at the end of the survey regarding the probable impact (severity) and prevalence (scope) of identified deficiencies. Subtasks include observations of medication passes and food service, resident interviews – group and individual – and record reviews.
- f. *Information analysis for deficiency determination* - During this task, the team members review and analyze all information collected to determine whether or not the facility has failed to meet one or more of the regulatory requirements. At this point, the team may decide that an extended or partially extended survey is necessary.
- g. *Exit conference* - The purpose of the exit conference is to inform the facility of the survey team's observations and preliminary findings. A *long-term care ombudsman*, an officer of the resident council and one or two residents must be invited to attend. The ombudsman's role in the exit conference is *as an observer only*: He/she is allowed

h. to respond to direct questions only. The team may provide an abbreviated conference specifically for residents after completing the required exit conference.

2. *Survey Report/Statement of Deficiencies and Plan of Correction*

While conducting the survey, BFS personnel record any violations of standards or deficiencies on a form. Deficiencies are classified according to their scope and severity and are reported on a CMS form 2567 called a "Statement of Deficiencies and Plan of Correction."<sup>9</sup> The CMS 2567 is reviewed and approved by BFS and then sent to the facility. The facility has 10 days to submit their plan of correction. The plan of correction must tell: (1) how the facility will accomplish corrective action; (2) how the facility will identify other residents that might be affected by the same practice; (3) what systemic changes will be made to prevent reoccurrence; and (4) how the facility will monitor corrective action to ensure it does not reoccur. BFS reviews the Plan of Correction, and determines if it is acceptable. This process takes about 30 days after the survey is completed.

Survey reports are public information and must be available in the facility to residents, families, and the general public.

Follow-up surveys are conducted to re-evaluate the specific types of care and services that were cited as deficient during the original survey. Because this survey process focuses on the care of the resident, revisits are almost always necessary to determine whether the deficiencies have indeed been corrected.

3. *Nursing Home Pre-Admission Screening and Resident Review*

Pre-Admission Screening (PASARR) is a screening process for persons seeking admissions to a Medicare/Medicaid certified home. The purpose of the screening is to assure that those persons with a severe mental illness or mental/developmental disability are not admitted to

<sup>9</sup>More information about scope and severity determinations can be obtained from the Idaho LTCOP.



nursing homes. The law requires the state to provide other settings for individuals identified by PASARR as inappropriate for nursing home care.

If a person is denied admission to, or a resident is asked to leave a home because of the results of the PASARR screen, they have a right to appeal this decision. Residents who have resided in a home for 30 months as of April 1990 are entitled to remain in the home.

#### 4. *Enforcement*

If a facility does not correct a deficiency cited in a survey or if it has repeatedly violated the same requirement, federal regulations provide for other enforcement mechanisms including:

- Assessing a fine;
- Placing a monitor in the facility;
- Appointing a receiver for facility;
- Denying, refusing or revoking a license;
- Suspending a license or issuing a provisional license; and
- Denial of payments for new admissions (Federal),
- Stop new admissions (State),
- Require in-service training of staff,
- Publicly listing these actions in the home and through BFS.

Enforcement experts believe that assessing fines for repeat offenders is the more effective enforcing mechanism or sanction. Closing a facility is the last resort since residents' lives are disrupted when they are moved and beds can be difficult to find.

Under federal law CMS can initiate a "fast track" de-certification in a Medicare SNF if the deficiencies are "life-threatening." Examples of life-threatening deficiencies are: non-functioning fire alarm system or administering the wrong medication to residents and causing them harm. In a "fast track", CMS gives the facility between two and twenty-eight days to correct a problem or they cancel the provider agreement.

This means the federal government would stop paying for Medicare recipients. The state then moves to revoke the license and cancels the Medicaid agreement, thus stopping both methods of payment. The purpose of the "fast track" is to get correction of serious deficiencies quickly.

When a "fast track" de-certification happens, BFS notifies the Office of the State Long Term Care Ombudsman. While the ombudsman holds no regulatory role, it is the mandate of the program to protect the rights of the residents. If a home's closure and the moving of residents is imminent, the ombudsman can (1) support or be the voice of the

residents during the "fast track"; (2) assure that the residents' choices for relocation are honored; (3) assure that the residents are prepared for a disruption or move to minimize transfer trauma; and (4) assure legal representation for residents.

5. *Facility Performance Indicators*

Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.

The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay (MDS). These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop quality measures that give consumers another source of information that shows how well nursing homes are caring for their resident's physical and clinical needs.

6. *Five Star Quality Rating System*

The Centers for Medicare and Medicaid (CMS) created the Five-Star Rating System to help consumers, their families, and caregivers

compare nursing homes more easily. The Nursing Home Compare web site (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html>), updated in April 2019, features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. There is one Overall 5-star rating for each nursing home, and a separate rating for each of the following three sources of information:

- Health inspections,
- Quality measures, and
- Staffing levels.

## MODULE 7

### A. Long-Term Care Residents

#### **Overview:**

This module provides information about the challenges residents may face in the long-term care environment and provides resources for the ombudsman in supporting the residents wishes.

#### **Learning Objectives:**

At the conclusion of this module, participants will know basic information about:

- Challenges residents may face in the long-term care environment
- Resources for the ombudsman in supporting residents.

#### **Contents:**

- ✓ Entry into Long-Term Care
- ✓ Decision Process
- ✓ Ombudsman Role
- ✓ Characteristics of Residents
- ✓ Adjustments to Institutionalization

*Duration: 1 hour*

## 1. Entry into Long-Term Care

The transition that elders and their families face when the individual moves from a community setting to an institutional setting is a difficult one. Many of the problems, e.g. physical disabilities or progression of a chronic condition, do not start with entry into the long-term care setting, but must be dealt with there. Other problems facing the new resident arise because of the nature of the setting itself and how services are delivered.

*Residents are individuals with distinctive personal preferences, needs, desires, and abilities.*

In addition to the individual characteristics that make each person unique, there are some general characteristics that describe individuals who live in facilities. This chapter points out a few of the most important characteristics pertinent to your work as an ombudsman. It also highlights some of the adjustments and reactions that typically accompany assisted living or nursing home life.

## 2. The Nursing Home Decision Process

The decision to enter a nursing home usually is made after a crisis when there are pressures to choose a nursing home quickly. But a nursing home should be selected only if the medical services are really needed and cannot be obtained somewhere else. If it is determined that nursing home care is appropriate for an individual, the method of payment for care determines how to proceed with the placement process.

### A. Idaho Specific Information

In Idaho the majority of nursing home care is paid for by Medicaid. In contrast, if eligible, Medicare may pay for skilled nursing care for up to 20 days. On the 21<sup>st</sup> day, if the resident meets the criteria, they will be required to pay a co-pay and Medicare may continue to pay a portion of the bill up to the 100<sup>th</sup> day of stay. A qualifying hospital stay of 3 nights determines eligibility and periodic re-evaluation is required throughout the 100-day eligibility period to make sure the medical need continues to meet Medicare criteria. If it does not meet the specific criteria, the Medicare payment will cease.

Idaho has a Medicaid Aged and Disabled Waiver Program (HCBS) that, for those that are eligible, will pay for assisted living and for some community-based long-term care. There is a cap on this rate and some facilities will not accept this amount as sufficient to cover expenses.

***Private insurance pays for very little nursing-type care in the home.***

### **3. The Ombudsman Role – Helping With Placement Decisions**

When an older person, or their family member, asks you for information about facilities or assistance in making a decision, your role as an ombudsman is summarized in the following points.

- ☐ Ask if the individual has considered other options, if appropriate. The answer may be apparent.
- ☐ Discuss the differences in the options that might be considered, in assisted living homes vs. nursing homes, for example;
- ☐ Give the consumer information about how to visit different facilities, what to look for, as well as printed information on selecting a facility. Resources include the following:

#### **Assisted Living Facilities**

- √ *Choosing an Assisted Living or Residential Care Facility*

<http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RALFChoosingALFacilityChecklist.pdf>

#### **Nursing Facilities**

- √ *“A Simplified Guide to Choosing a Nursing Home.” Consumer Information Sheet by the National Consumer Voice for Quality Long Term Care (NCCNHR) 1424 16th Street, NW, Suite 202, Washington, DC, 20036; 202-332-2275; Fax: 202-332-2949; email:*

[info@theconsumervoice.org](mailto:info@theconsumervoice.org); website:

<https://theconsumervoice.org/issues/recipients>

Be prepared to share facility survey reports with the consumer if they contain useful information. Share pertinent ombudsman program information about the facilities that the consumer is considering, in

keeping with guidance from the State Long Term Care Ombudsman. Idaho nursing home reports can be found at:

[www.healthandwelfare.idaho.gov/Medical/LicensingCertification/FacilityStandards/LTCSurveyResults/tabid/315/Default.aspx](http://www.healthandwelfare.idaho.gov/Medical/LicensingCertification/FacilityStandards/LTCSurveyResults/tabid/315/Default.aspx). Assisted

Living survey reports can be found at:

<https://www.flareslive.com/portal/SearchFacility.aspx>

Provide basic information about financial coverage: Medicaid, Medicare, and Medicaid Waiver Programs. Resources for consumers include the following:

- √ *“Important Contacts: Financing Long Term Care.”* Located in **Module 6, Long-term Care: Facilities, Regulations, and Financing**
- √ *“What is Medicare?”* Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, available via CMS website: <https://www.medicare.gov/forms-help-resources/find-compare-doctors-hospitals-other-providers#hospital-compare>, as well as other types of information about Medicare and Medicare Health Plans. These resources are available from any Social Security Office or by writing: Medicare Publications, CMS, 6325 Security Boulevard, Baltimore, MD 21207.

#### 4. Characteristics of Long-Term Care Residents

In the absence of a national definition and oversight of assisted living facilities and/or board and care facilities, we find that there is a wide variety of the types of residents living in these homes. While many if not most are older Idahoans requiring some assistance with activities of daily living you may also find the following:

A. Residents with Acquired Immunodeficiency Syndrome (AIDS)<sup>1</sup>

Because of misperceptions and lack of knowledge regarding HIV/AIDS, nursing homes may be unwilling to accept these residents. It is a violation of Section 504 of the Federal Rehabilitation Act to discriminate against someone based on disability. Since the AIDS disease is twice as prevalent among Blacks and Hispanics, discrimination against these populations violates Title VI of the Federal Civil Rights Act. These laws apply to all facilities that accept Medicare, Medicaid, or those financed through the Hill-Burton program.

B. Residents with Developmental Disabilities

As an ombudsman, you will encounter some younger residents. The majority of these young residents are *not sick* but are disabled with more or less permanent impairments. Their need for nursing care is often far less than that of older residents. These individuals have the same rights as other residents and may also have legal remedies for their problems, which exceed the remedies available to others.

*Many residents in assisted – living homes have cognitive impairments, including a diagnosis of dementia. They need assistance with bathing, taking medication, and frequently need help in other areas of daily activities.*

<sup>1</sup> From the Georgia LTCO Training Manual, developed by Leigh Anne Clark.



The major conditions considered in determining *developmental disabilities* are:

- Manifested prior to age 22;
- Likely to continue indefinitely;
- May occur singly or in combination with other conditions that impair physical and mental functioning;
- Requirements of a sequence of care, treatment, and individualized support of lifelong or extended duration.

The severe, chronic conditions that are classified as developmental disabilities result in substantial *functional limitations* in three or more of the following areas of major life activity:

- Self-care
- Mobility
- Understanding and using language
- Self-direction
- Learning
- Capacity for independent living

A developmental disability substantially limits an individual's ability to function in society. This definition is written with an emphasis on *functional limitations* imposed by a disability, rather than on the origin of the disability. The following are examples of disabilities that generally occur during the developmental period and may be considered as developmental disabilities:

- Epilepsy
- Muscular dystrophy
- Spina Bifida
- Blindness and deafness
- Cerebral palsy
- Autism
- Moderate, severe, and profound mental retardation

- Similar and related conditions that impose physical and mental limitations.

### *1. The Ombudsman Role With Individuals Who Have Developmental Disabilities*

- ✓ Educate yourself about developmental disabilities, especially the types of disabilities you encounter.
- ✓ Be aware of the legal rights of developmentally disabled nursing home residents, in addition to the rights of all residents. Certain federal laws establish rights for developmentally disabled persons. *The most important of these are: (a) the right to appropriate treatment, and (b) the right to the least restrictive environment.*
- ✓ Be an advocate. Assist in self-advocacy and provide information about rights, alternatives, and options to residents and staff. Provide the community with information on needed services. Always treat the resident with respect and insist that others do also.
- ✓ Be aware of the need for social interaction with people in the community and for interactions with others of the same and different ages. Assist in meeting this need.
- ✓ Encourage the staff of nursing homes and the community to become educated about developmental disabilities, the rights of the developmentally disabled, and the principle of normalization.
- ✓ Keep these points in mind when relating to residents:
- ✓ One **disability does not imply another**. For example, a severe limitation in speech may give one the impression that the individual is intellectually disabled, which may or may not be the case. *Do not assume it is.*
- ✓ Remember that everyone has a past and a future. Do not assume that a person has "always" been as he/she is now or "always will be" this way. A person's "potential" may be determined by the limitations others set.
- ✓ Some placements do not have to be permanent if viewed and treated as temporary; help others to see that and act accordingly.

- ✓ Assist residents in getting to know other residents with similar interests and in becoming less isolated.
- ✓ Treat **residents with respect**, which is implied in how you say something as well as what you say. Respect means treating adults as adults; it also means acknowledging individuals with disabilities as valuable citizens, not objects to be pitied.

### C. Residents with Mental Illness

Mental illness generally refers to psychoses like schizophrenia and affective disorders like bi-polar (manic-depression) personalities. These are serious diseases and need to be distinguished from situational depressions that result from grief or a loss. Many mental illnesses are treatable and reversible but some, like schizophrenia, can last a lifetime and need continued treatment.

Some of these residents have long-standing diagnoses such as schizophrenia or depressive disorder for which they have received treatment by mental health professionals. These treatments continue in the facility and may include appropriate psychoactive drug therapy. Their care plans need to show coordination and cooperation between facility staff and mental health professionals who work with them. These residents may have been living either in the community or in a mental institution prior to moving into the nursing home. (See Attachment C for more information about care planning).

Residents with mental illness who were previously in institutions may have developed and used specific coping behaviors in that setting that do not work in the nursing home.

These individuals need special understanding and attention to prevent stigmatization and isolation in the new setting. Other individuals living in nursing homes may have histories of disorders that affect their mental, physical, and social functioning.

*Depression is under-diagnosed and under-treated in nursing home residents who have not had a history of depressive illness.*

These disorders include alcoholism and a pattern of abusive behavior. Family members need to be truthful in sharing this kind of information with staff to facilitate better understanding for assessment and care planning to meet the resident's individual mental health needs.

## 5. Adjustments to Institutionalization

Long-term care facilities can either compound the sense of loss an individual experiences upon admission or help preserve an individual's sense of self. Sometimes, facilities compound an individual's dependency by taking away control and choice. Living in a facility doesn't have to be that way. A facility can lessen the impact of negative factors that may occur as a normal part of moving into an institution by:

- Taking the time to learn who the resident is;
- Respecting and responding flexibly to the individual and his/her customary daily routine;
- Building on his/her *strengths* to meet his/her needs.

When care is provided based on the above three practices, the facility is providing *individualized or person-centered care*.

Regulations requires nursing homes to:

- Make reasonable accommodations of individual needs and preferences;
- Enable residents to exercise some choice and control in living patterns;
- Support the physical and psychosocial well-being of each individual resident.

This direction prompts nursing homes to build on the strengths of aging as well as to address the weaknesses. An individual's strength may come from all that he/she has survived and how he/she has learned to cope. Other sources of strength may be: the patterns of living that the individual has developed, which must support his/her needs; his/her knowledge and self-awareness; and his/her preferences and priorities. Although the requirements are for nursing facilities, assisted living homes can implement

similar steps to help residents be *at home* in their new setting.

The ombudsman plays a critical role in supporting residents through the process of transition so that their continued life may be as true to their needs and patterns as possible. This section describes some of the forces that make this continuity of life difficult and the factors to which an ombudsman must help residents respond.

#### A. Reactions

Although each individual moves through change independently and differently, almost everyone experiences some of the following reactions:

- Loss of self-esteem - Have I failed in my independence? Doesn't my family want me?
- Abandonment - Almost everyone around me is new; the familiar caregivers who know me and how I like things are not with me.
- Anger - (*expressed toward family and/or staff or in depression resulting in anger with self*). I have lost control. I've lost my choice over where I live; I am being asked to adjust to too many things
- Dependency - I feel as if I have to depend on others for everything. I feel like giving up or withdrawing from all these strangers. I do less and less for myself as time passes.
- Sick role. I'm really frail and ill. I've never experienced so much discomfort, pain, or dependency.
- Decline of intellectual performance. I'm having trouble remembering where I am, where my room is, and what I'm supposed to do. I hardly recognize anyone.

#### B. Setting Goals.

Goals should be realistic, considering the resident's abilities and the institutional context. (A vegetable garden may be out of the question, but a few plants or a small garden plot may not be; reading long novels may be difficult, but articles and short stories may be within reach. The Need

to Maintain or Regain Abilities. Demands must be carefully defined; expectations must be realistic.

Ombudsmen may support, encourage, and help residents and their caregivers.

#### 1. *Supported Decision Making*

Every resident has a right to make choices. Supported Decision Making provides a network of support to assist the resident in making as many of their own choices as possible and can be an alternative to a more restrictive guardianship. The ombudsman can be instrumental in assisting with an individualized plan of supports for residents needing this type of assistance. See [www.mychoicematters.idaho.gov](http://www.mychoicematters.idaho.gov) for more information.

*Especially important for the ombudsman is the relationship between resident, staff, and family. Ombudsmen should become skillful in distinguishing between real problems reported by family members who express concern for the care their relatives are receiving, and imagined or exaggerated problems.*

#### C. Effects of Institutionalization on the Family.

Many families struggle with the decision to have a relative move into a facility. Family members may feel that they have failed in providing care for their loved one. The move into a facility may often be defying the expressed wishes of the older person.

Once the move is made, family members' feelings may include guilt, anxiety, confusion, and indecision. Expressions of family guilt may be acted out in a number of ways: possibly in the way the family speaks to the resident, in an angry, babyish, or child-like manner; in the insistent demands it makes on the facility staff; or in staying away from relatives altogether. Families either may be over-solicitous or over-protective. Roles may be uncertain; relationships may be strained; and conversations may be difficult. When familiar patterns of relating are no longer appropriate, some families may need assistance in establishing new patterns.

Conflicts may arise as family members disagree over such matters as laundry, bringing food, or visits away from the nursing facility. Increasingly, the ombudsman may be asked to help family members reconcile their differences when faced with decisions over withholding treatment from a terminally-ill resident. The ombudsman must remember his/her role as an advocate for the *resident* and work to involve the resident in discussions and decisions about care.

Family members need to talk with each other and with the resident. Decisions about care, treatment, visitation, and responsibilities are best made if thoroughly discussed with the resident and all interested family members. The ombudsman should be alert to ways to encourage such discussions.<sup>2</sup> The ombudsman must protect the resident's rights and interests in spite of what the family wants. If the ombudsman develops a cooperative relationship with the administrator or social services, he/she may be able to assist families even prior to the resident's move into the facility. (However, an ombudsman must never forget that it is imperative there be a professional and collaborative working relationship only to avoid creating even the perception that he/she is too friendly with staff. The ombudsman works for the resident and must be objective in order to gain trust.)

(However, an ombudsman must never forget that it is imperative there be a professional and collaborative working relationship only to avoid creating even the perception that he/she is too friendly with staff. The ombudsman works for the resident and must be objective in order to gain trust.)

<sup>2</sup> A resource pertinent to this topic is: Sara Hunt, *Working Through Ethical Dilemmas in Ombudsman Practice*, NCCNHR, and National Center for State Long Term Care Ombudsman Resources, Washington, DC.

## **MODULE 8**

### **A. Communication**

#### **Overview:**

As an ombudsman you will need to practice effective communication which includes a knowledge of:

- Factors influencing communication;
- Specific tips for communicating with residents who have selected disabilities or conditions;
- How to listen effectively.

#### **Learning Objectives:**

At the conclusion of this module participants will know basic information about:

- Setting the stage for communication
- Verbal communication
- Non-verbal communication
- Communicating with residents with selected conditions
- Listening
- Barriers to communication

*Duration: 2 hours*



## 1. Setting the Stage for Communication

*As an ombudsman, your visits are to be purposeful, with the resident as the focus.* Although residents will become your friends, you are there to be an advocate. You have knowledge, training, and skills to be used on behalf of residents. Your communication skills will either act as a barrier to working with residents or greatly facilitate that work. You will be visiting with residents in their home—whether the facility is a “temporary” home or a long-term place of residence.

Before reviewing tips on getting to know residents, take a few moments and think about yourself and your experiences.

- When you meet someone for the first time, what makes you feel comfortable with that individual?
- What factors give you an uneasy feeling about meeting someone you don’t know?
- When someone you haven’t met comes to the door of your home and you invite the person in, what “rules of behavior/manners” do you expect from that individual?

As you read and discuss how to get acquainted with residents as an ombudsman, think about your answers to the preceding questions. You’ll probably find similarity between your personal responses and the way you need to interact as an ombudsman.

Your effectiveness as an ombudsman will significantly depend upon your ability to develop and sustain a relationship of trust with individual residents.

Although the focus of this chapter is on skills for visiting with residents: the tips, barriers, and other aspects of cultivating a trusting, respectful relationship, can also be applied to interactions with other individuals: family members, facility administrators and staff, and other professionals.

## 2. Ombudsman Guidelines For Visiting With Residents

The following tips are basic guidelines for getting acquainted with residents. If the purpose of your visit is related to a complaint, you will still follow these guidelines but with a more specific focus. Additional information about a more focused discussion is in *Module 4, The Problem-Solving Process: Investigation*.

There are some factors that can prepare the way for your interaction with another person. These, if properly attended to can increase the chances that your communication will go the way you would like. This is especially true when working with nursing facility residents.

- √ Always introduce yourself, name and role/affiliation, unless the resident knows you by name or recognition. Do not ask the resident, “You remember my name, don’t you?” (or a similar question). That type of question puts the resident on the spot, elevates the resident’s stress level, and calls upon the resident to utilize short term memory, which normally is more difficult to use as a person ages.
- √ Greet the resident by Mr., Mrs., Miss, or Dr., and given name unless the resident asks you to use another name.
- √ Always knock on the door to a resident’s room before entering, even if the resident can’t verbally respond or if the resident is watching you approach. Knocking acknowledges that the room is their “space” and home. It also conveys a sense of respect for their privacy and dignity.
- √ Choose an appropriate place for the type of conversation or visit you plan to have with the resident. If you are just greeting people, a day room or porch setting is appropriate if that is where the residents are sitting. If you need to discuss personal information, find a setting with privacy and quiet. The setting in which communication occurs directly impacts the nature of the interaction.
- √ Cultivating friendly, trusting relationships takes time. Be patient in visiting. Allow residents to get to know you while you are learning about them. Rarely does a person divulge their innermost thoughts or problems until a trusting relationship has been established.

- √ Be dependable. Visit or check back when you said you would. Promise only what you can deliver/control.
- √ Be honest. Avoid giving false hope or stating platitudes. It's OK to admit, "I don't know."

### 3. Types of Communication

#### A. Verbal Communication

The use of spoken words to send a message is called verbal communication. There are two key components of this type of communication:



Voice tone can add meaning to the words that are uttered. The tone of one's voice often holds significant clues as to the underlying meaning of a statement. Voice tones certainly place emphasis where the speaker intends. Consider, for example, how the word "yes" can assume different meanings by varying the tone of expression.

**If it said:**

softly  
loudly  
sharply  
rising

**It can mean:**

friendliness  
anger  
annoyance  
a question

Words are unique to humans. Depending on how it is used, conversation can create understanding or misunderstanding. Carefully chosen words bridge gaps and can also be used to mend fences. Be sure that the words you use have the same meaning for the person with whom you are speaking as they do for you.

*For example: If you told an administrator that Mrs. Jones lost her purse, would the administrator think that the resident forgot where she placed her purse or think that Mrs. Jones's purse was stolen?*

*For example: If you asked Mr. Green how he spends his time, would he laugh at you and say, "I can't spend time! I can only spend money, and I don't have any of that!"*

## B. Non-Verbal Communication

Non-verbal communication involves the sending of messages without the use of words. It is a continuous process and is the principal means by which feelings and attitudes are conveyed. Awareness of nonverbal cues is necessary to assure that a mixed message is not sent, a contradiction between the verbal and the nonverbal message.

### 1. *Facial Expressions*

Seldom are we expressionless. Our faces portray a wide range of emotions and reactions, such as caring, disgust, inattention, or doubt. Facial expressions can be used to show that we understand or are in agreement (smiling or nodding) or can show we do not understand and need clarification (a quizzical look, eyebrow tightened). Appropriate facial expressions on the part of the ombudsman match the resident's mood and expressed feelings.

### 2. *Eye Contact*

The eyes themselves can send several kinds of messages. Meeting someone's glance indicates a sign of involvement or of confidence. Looking away signals a desire to avoid contact. Establishing eye contact indicates an interest in what someone is communicating. Eye contact should be spontaneous, where the listener looks at the speaker but also lets the eye drift occasionally. A person's comfort level with direct or sustained eye contact is influenced by that individual's culture and background.

### 3. *Touching*

Touching is an important type of nonverbal communication. Touch is particularly significant to the older person. As people age and become

detached from the mainstream of society, and as they experience both personal and social losses, chances for personal contact decrease. Thus, touching becomes a meaningful contact. Touching is especially effective with individuals who have sensory impairments or who are having difficulty concentrating. Sometimes a touch of the hand or a pat on the knee can help a resident focus on your conversation. At other times, that kind of touch serves to establish a bond, a link that precedes dialogue.

Touch expresses to the other person an acknowledgment of his/her existence. It says, "You are still a person with life and dignity."

**Touching can convey**

*Warmth – Caring – Understanding – Sympathy – Compassion*

As important as touch is, remember: touching and one's comfort with being touched is a very individualized characteristic. Some people like to be touched, others don't. Be sensitive to each resident's response to touching. Get to know the resident and let them know you before you use this communication technique.

**4. Distance/Personal Space**

The way people use space is also part of nonverbal communication. Each of us has a variable size of personal space. Personal space refers to the distance that we put between ourselves and others.

There are four distances that we use, depending on how we feel toward the person with whom we are communicating;

- a. *Intimate Distance* – is usually reserved for people with whom we feel emotionally close. The zone begins with skin contact and ranges out to about 18 inches.
- b. *Personal Distance* – can range from 18 inches to about 4 feet. Here again, the contact is rather close, but less personal than the intimate distance.

- c. *Social Distance* – ranges from 4 feet to 12 feet. This is the distance at which most business situations occur, or ombudsmen deal with residents.
- d. *Public Distance* – runs outward from twelve feet. The closer range of public distance is the one most teachers use in the classroom.

As you seek to communicate effectively with others, you must be aware of their personal space. If you are trying to establish rapport, you will respect their comfort with various degrees of physical closeness. However, there may be other times when you will purposefully “invade” someone’s personal space.

#### 5. *Gestures and Movements*

Two other methods of conveying feeling and attitudes are *gestures and movements*. Gestures can be used to punctuate a statement; (e.g. pointing to emphasize or signaling to get attention). Movements all too often indicate tension or boredom.

Shifting in one’s seat, foot tapping, or finger drumming all point to inattentiveness and should be restricted. By paying attention to these, you can tell when a resident is nervous, exhausted, ready to end your visit, or any one of a number of other messages. Gestures and movements do have meanings.

These meanings may be different in different cultures or ethnic groups. Making eye contact while speaking may be a sign of honesty in communication in one culture, while being impolite and challenging or defiant in another culture. Be sure to verbally check your interpretation of the meaning of another person’s gestures and movements. An example: “*Mr. Bader, you seem tired, let’s continue this conversation next Tuesday when I return for a visit. Is that all right?*” To be skilled as a communicator, you need to be able to read the meanings of gestures and movements and to use them effectively to convey your messages.

## 6. *Silence*

Sometimes the absence of words is the most effective form of communication. Words or movements are not always necessary to express a message. Silence has a number of uses.

It can:

- a. mean hostility, anger, or depression
- b. be soothing, showing empathy
- c. express concern and caring; provide time to organize one's thoughts
- d. diffuse tensions
- e. offer time for consideration of ideas or for interpretation
- f. provoke a response from the other person
- g. be a controlling device
- h. be a resistance to saying what should not be said

Silence is a very powerful communication technique. Visitors should be comfortable with silence while visiting residents. At times, the physical presence of another person is all the reassurance and comfort that a resident needs.

## 4. **Communicating with Residents with Selected Conditions**

The conditions described below are frequently encountered among residents in a long-term care facility. Residents with these conditions may seem almost invisible because of their inability to express themselves in an articulate manner. To communicate with these residents, it takes patience, practice, energy, and time. The results, however, are well worth the effort.

### A. Hearing Impairments

A discussion of hearing loss is included in the *Module 2, The Aging Process*. Some communication tips to consider using are listed.

1. Be sure the individual sees you approach; otherwise, your presence may startle the person.

2. Wait until you are directly in front of the person, have that individual's attention, and are close before you begin speaking. Place yourself at eye level with him/her whenever possible.
3. Find out if the resident has ever worn a hearing aid. If the resident has, and the hearing aid is not visible, find out if it is in the resident's room, at the nurses' desk, or somewhere else. Ask why the resident is not wearing the hearing aid.
4. If the person wears a hearing aid and still has difficulty hearing, check to see if the hearing aid is in the person's ear. Also ask if it is turned on, adjusted, and has a working battery. If these things seem to be fine and the resident still has difficulty hearing, find out when the resident last had a hearing evaluation.
5. When carrying on a conversation, reduce or eliminate background noise as much as possible.
6. Be sure that the light is not shining in the resident's eyes.
7. Speak in a normal fashion without shouting. Speak slowly and distinctly. Lower your voice tone, speaking as if you have a cold.
8. Use simple, short sentences to make your conversation easier to understand. If a person has difficulty understanding something, find a different way of saying the same thing, rather than repeating the original words over and over.
9. Keep your hands away from your face while talking. If you are eating, chewing, or smoking while talking, your speech will be more difficult to understand.
10. Recognize that people with hearing impairments do not hear and understand as well when they are tired or ill.
11. A touch on the hand may aid in concentration, thus improving comprehension.
12. Write messages if necessary.
13. Allow ample time to converse with a hearing-impaired person. Being in a rush will compound everyone's stress and create barriers to having a meaningful conversation.



## B. Deafness

Communicating with residents who are deaf is similar to communicating with individuals with hearing impairments.

- ☐ Ask staff how they communicate with the resident.
- ☐ Write messages if the resident can read.
- ☐ Use a “picturegram” grid or other device with illustrations to facilitate communication.
- ☐ Be concise with your statements and questions.
- ☐ Utilize as many other methods of communication as possible to convey your message.
- ☐ Allow sufficient time to visit with the resident without having to be rushed or under pressure.

## C. Visual Impairments

Although the visually-impaired person can still hear, adaptive measures can aid communication. More information about visual impairments can be found in *Module 2, The Aging Process*, under the subsection II, “Biological Aspects of Aging”. The following suggestions are ways to improve communication with a visually-impaired person.

1. If you are entering a room with someone who is visually impaired, describe the room layout, other people who are in the room, and what is happening.
2. Tell the person if you are leaving. Let him/her know if others will remain in the room or if he/she will be alone.
3. Use whatever vision remains.
4. Allow the person to take your arm for guidance.
5. When you speak, let the person know whom you are addressing.
6. Ask how you may help (e.g. increasing the light, reading the menu, describing where things are, etc.).
7. Call out the person’s name before touching. Remember that touching lets a person know you are listening.
8. Allow the person to touch you.
9. Treat him/her like a sighted person as much as possible.
10. Use the words “see” and “look” normally.
11. Legal blindness is not necessarily total blindness. Use large movement, wide gestures, and contrasting colors.

12. Explain what you are doing as you are doing it, (e.g. taking notes, looking for something, or putting away the wheelchair).
13. Describe walks in routine places. Use sound and smell clues.
14. Encourage familiarity and independence whenever possible.
15. Leave things where they are unless the resident asks you to move something.

**D. Aphasia**

*Aphasia is a total or partial loss of the power to use or understand words.*

It is often the result of a stroke or other brain damage. Expressive aphasics are able to understand what you say; however, receptive aphasics are not. Some individuals may have a bit of both kinds of impediment. For expressive aphasics, trying to speak is like having a word “on the tip of your tongue” and not being able to call it forth. Some suggestions for communicating with individuals who have aphasia follow.

1. Be patient and allow plenty of time to communicate with a person with aphasia.
2. Be honest with the individual. Let her know if you can’t quite understand what she is telling you.
3. Ask the resident and the staff how best to communicate. What techniques or devices can be used to aid communications
4. Allow the aphasic to try to complete her thoughts, to struggle with words. Avoid being too quick to guess what the person is trying to express.
5. Encourage the person to write the word he is trying to express and read it aloud.
6. Use gestures or pointing to objects if helpful in supplying words or in adding meaning.
7. A “picturegram” grid is sometimes used. These are useful for “fill-in” answers to requests such as, “I need” or “I want”. The resident merely points to the appropriate picture.
8. Use touch to aid in concentration, establish another avenue of communication, and to offer reassurance and encouragement.

**E. Alzheimer’s Disease or Related Disorders**

A number of suggestions for communicating with residents with dementia are given in the *Module 2, The Aging Process*. There are a few additional

tips for talking with someone who has Alzheimer's or a related disorder.

1. Think about how you are presenting yourself (particularly your body language). Sitting or kneeling at the person's level is non-threatening. Make sure you make eye contact and have the person's attention.<sup>1</sup>
2. Speak in a normal tone of voice, and greet the resident as you would anyone. Use a calm gentle, matter-of-fact approach.
3. Begin conversations with orienting information: *"Hello, Mrs. Jones, I'm Beth, the ombudsman."*
4. Use short, clear, simple, and concrete words.
5. Minimize hand movements that approach the other person.
6. Avoid a setting with a lot of sensory stimulation, like a big room where many people are sitting and talking, a high traffic area, or a very noisy place.
7. Be respectful of the person's personal space and observant of his reaction as you move closer.
8. If the resident paces, walk in step with them while you talk.
9. Use distraction if a situation looks like it might get out of hand (e.g. if a resident appears about to hit someone or if a resident seems to be going outside of the nursing facility grounds).

*When verbal communication fails:*

- ✓ *If you cannot understand what the person is saying, listen to the "feeling" of what he is saying.*
- ✓ *Try distraction or redirection if the person gets too frustrated.*
- ✓ *Ignore a verbal outburst if you can't think of any positive response.*
- ✓ *Use touch. Touching the person gently can convey many things. It can show that you care, guide the person to do what you want, and help to relax the person. It can also distract you both from a frustrating moment.<sup>2</sup>*

(Note: See additional information on the ICOA website at:

<https://aging.idaho.gov/dementia-skills>)

<sup>1</sup>From the Midland Chapter Alzheimer's Disease & Related Disorders newsletter. August 1999. Midland, MI

<sup>2</sup>From "Care of the Person with Dementia: A Training Package" by Anne Robinson and Beth Spencer. Eastern Michigan University

## F. Unresponsiveness or Withdrawal

Unresponsive residents are individuals who seem incapable of giving a verbal or nonverbal response. These may be residents: *who are comatose or seem that way; are withdrawn and do not acknowledge your presence; who seem to be completely in a world of their own; or for whom no effective method of communication has been found.*

Communicating with unresponsive residents is usually very difficult for most people because you receive no feedback. You do not know if your message has been received or what the other person's reaction is. Sometimes unresponsive residents have shocked their visitors by saying a few words or by giving a clear response after weeks of no obvious response. Although there is no one correct way to visit with these residents, there are a few tips to remember.

1. Be sure to visit unresponsive residents. If a resident is difficult for you to visit, other people may not visit that resident either for the same reasons you have difficulty. These residents are often the least visited, and thus receive the least stimulation of all the resident population. Therefore, they may be among those individuals most in need of a visit.
2. Be present for the resident on a routine basis. If possible, hold the resident's hand or give a pat on the arm while verbally introducing yourself.
3. The visit may be short. You may only state your name, the purpose of your visit, and stay for a few minutes of silent companionship.
4. While visiting the resident, observe the resident's appearance. What kind of care does it seem the resident is receiving? Do you notice any changes in the resident's appearance from one visit to the next?
5. If appropriate, try different kinds of sensory stimulation as well as different conversational topics to see if something "strikes a chord" of responsiveness in the resident. You might bring music, a feather, a carpet square, or a bright picture to try.

### G. Language Differences

With the rich diversity of languages and cultures the United States has attracted, it comes as no surprise that ombudsmen frequently face communicating with older persons who speak a foreign language. Unless the ombudsman happens to speak that particular foreign language, an interpreter will be needed to help translate. Resources for interpreters include members of the resident's church, members of an ethnic social club, foreign language department at the university, and foreign students attending a university.

*If you use an interpreter:*

- √ Review rules of confidentiality with them.
- √ Inform them that they must translate word for word – *do not put into own words.*
- √ Inform them that they may be called to testify in a hearing, if necessary.
- √ Remind them they must remain neutral.
- √ Consider tape recording for second interpreter, if necessary. If taping, make sure to get the resident's expressed permission on tape.

### H. Communicating With Care Providers

Much of an ombudsman's work is spent communicating with residents of nursing facilities. An ombudsman also needs to communicate effectively with care providers. When communicating with care providers, remember the tips that follow:

- √ Clearly explain the nature of your role: *why you are there, what you'll be doing, and what they can expect from you.*
- √ Be sure to acknowledge the good work that providers do.
- √ Remember that care providers are very busy. Be respectful of the demands on their time. Be concise with your communication.

## 8. Listening

What is verbalized in communication is only one side of the coin. The other

side is listening. Concentrate on improving your listening skills as you become an experienced ombudsman. You will experience many rewards from developing this skill as well as obtain better information on which to judge situations.

***Active listening is the act of hearing and responding both to the content and to the feeling of what is being said.*** Words are often a cover up of what people feel. Most of us have learned to use words to protect ourselves. Learn to listen for the feelings that are behind those words.

For example:

In the statement: *"I don't want my dinner"*, the content is simply the information stated about the speaker not wanting dinner. The feeling could be that the speaker is not happy about something, dislikes the food, or wishes to register a protest about something by not eating dinner.

By employing an active listening strategy, one would respond to the emotional content of the message. For example, one could respond to the feeling behind what was said by saying something like, *"It sounds as if you're not happy with the food here,"* or *"You must be upset about something."*

***A second aspect of active listening is feedback.*** Within this listening strategy, one is making statements that confirm that you are listening and encouraging the speaker to go on. Feedback is an excellent way to confirm that the information you are receiving is an accurate representation of what the sender of the information is intending for you to receive.

Some useful phrases for building understanding and receiving feedback are:

- "You seem really..." (identify the feeling);
- "From your point of view...";
- "If I understand what you're saying...";
- "I'm not sure I understood you, you mean...?";
- "How do you feel about...?";
- "Do you mean...?"

Active listening is a very effective communication tool. Using this listening strategy is helpful when you wish to convey that you are interested in what is

being said, show that you understand what the other person is saying and feeling (not necessarily that you agree but that you hear and understand), help the speaker explore all angles and come up with her/his own answers, and encourage the other person to keep talking.

However, active listening is not always appropriate. For instance, you would not use it when you don't have time to listen or when seeking specific information. If the speaker is only imparting or asking for information, there is no need for active listening.

## 9. Barriers to Communication

No one likes to hear bad or sad news.

Sometimes a remark or information about a situation is personally threatening to the ombudsman because of the memories or

fears they evoke. Nevertheless, the ombudsman role means that you will sometimes hear residents discuss all of the above. Your response can erect a barrier to communication, or it can open the door to understanding and trust. It can mean the difference in being effective as an ombudsman or being ineffective. In fact, the way you respond will make the difference in whether or not residents confide in you. Five barriers to communication and examples follow.

*The way you respond to a resident will determine whether or not he/she will confide in you.*

### A. Changing The Subject When The Topic Is Uncomfortable For You.

1. If a resident wants to talk about death and dying or about how much he misses his wife don't change the subject because you find the topic morbid or depressing.
2. Maybe the resident wants to express their anger towards a daughter. Hearing this makes you uncomfortable because you know the daughter. Your role as an ombudsman is to listen and hear the

resident's position. You ***are not*** in a position to defend the daughter. If ever there is a case where you cannot maintain an objective perspective, refer the case to someone else and excuse yourself.

B. Offering False Hope, Reassurances Or Platitudes.

- When a resident says she hopes her doctor (son, daughter, etc.) comes soon, refrain from saying, "I'm sure he will." Be positive about the statement you make before you respond.
- A resident tells you, "I hope I get over this problem soon; I don't know what I will do!" Don't say, "I'm sure everything will work out fine." Also avoid statements like, "Don't think *about things like that.*"

C. Glossing Over Information The Resident Shares With You About The Facility Or About Her Treatment. Avoid "Tuning Out" Or Selectively Hearing Problem Statements.

- If a resident says, "They don't treat me very well, but I'm managing to take it one day at a time." Don't respond, "Well, you know they have a big job to do and can't please everyone."
- A resident might say, "I never get bathed and dressed in time for the morning craft class." In reply, a statement like; "*I'm sure the nursing assistants work as fast as they can. This is a big facility, and someone has to be at the end of the schedule,*" might impart a sense of futility to the resident.

D. Assuming The Role Of "Neighborhood Friend" When The Resident Is Revealing Personal Information

- A resident describes her physical problems. Do not say, "My grandmother had that and..." (discuss your grandmother's condition).
- A resident confides in you. Your response is, "I know what you're talking about," and proceed to tell the resident all about your situation. This kind of response does not pick up on what is important to the resident, it shifts the focus of the conversation to you, and it can



consume valuable time in the nursing facility.

E. Letting The Administrator Or Staff Monopolize Your Time:

Although cultivating a good, working relationship with the administrator and staff is very important, you are in the facility to visit the residents. Nursing facility personnel can either consciously or unconsciously, consume much of your time. Be sure your visits with personnel are purposeful, not just friendly chat sessions unrelated to your mission in that facility. This can erect a barrier to communication by severely limiting the amount of time you have with the residents or create a perception that you are too friendly with staff.

One or more of these five barriers may be very natural and easy to slip into without being aware of what you are doing. Some of them represent ways we have of protecting ourselves or of controlling the conversation. They may also be representative of the way you typically visit with a friend. These can work in friendship relationships but are not appropriate for your role as an ombudsman.

*Employ active listening and/or some of the nonverbal techniques, especially touch and silence, to respond to situations like the above examples.*

As an ombudsman, your visits are to be purposeful with the resident as the focus. Your communication skills will either act as a barrier to working with residents or will greatly facilitate that work.

As you listen to residents and observe their care, be very attentive and sensitive to what you see and hear. As an ombudsman you are in a unique position to educate residents regarding their rights and services to which they are entitled. You also have a responsibility to observe the overall care that the facility provides. To do this, requires having the rapport of a good friend with residents, using active listening skills, and remaining alert to clues you see and hear. Here are some examples of listening for clues that may point to an underlying problem/concern or for opportunities to provide information.

- √ In the course of a conversation, a resident says, "I used to complain about always having cold coffee, but I don't anymore. That's something I'll have to learn to live with. I guess I really shouldn't expect the service here to be like a restaurant."
- √ An ombudsman might ask, "What happened when you complained about having cold coffee?" This might be a time to explore the coffee service, the way the facility responds to complaints, and underlying concerns the resident might have regarding the quality of services in general.
- √ As you visit, you notice that a resident seems unusually tired. She says that she was up most of the night giving her bed-bound roommate water, calming her fears, and trying to get her to sleep. She says she doesn't know what would happen to her roommate if she didn't take care of her.
- √ As an ombudsman, you could inquire about the nursing service at night, the resident's sense of responsibility for her roommate, the resident's desire to transfer to another room where she might get more sleep, or any underlying concerns the resident might have regarding the care she would receive if she were bed-bound.
- √ If a resident tells you a story, listen carefully and try to determine why the resident chose this time to tell you. Is the resident merely sharing a bit more of herself with you? Is the resident trying to draw a parallel to some aspect of nursing facility life? ***Remember to solicit feedback before you reach any conclusions about the purpose of the story.***
- √ As an ombudsman, make a conscious effort to continually *listen and observe* while you are inside the nursing facility. These skills take time, energy, and practice. They make a critical difference in your effectiveness as an ombudsman.

## **MODULE 9**

### **A. National Ombudsman Reporting System (NORS)**

**Located on the National Long-Term Care Ombudsman Resource Center website**

[https://ltcombudsman.org/omb\\_support/nors/revised-nors-data-collection#training](https://ltcombudsman.org/omb_support/nors/revised-nors-data-collection#training)

#### **Overview:**

Each State Long-Term Care Ombudsman program is required by the Older Americans Act to advocate for residents of nursing homes and assisted living homes and report their work to the Administration for Community Living (ACL) Administration on Aging (AoA), to be summarized in NORS. Data has been collected since 1996 and is available on the ACL website.

NOTE: A revised Ombudsman Reporting System will be implemented on October 1, 2019. Training materials below address these changes. Additional information will be included as it becomes available.

#### **Objective:**

At the conclusion of this national online module, participants will know how to record their work in the federally required National Ombudsman Reporting System (NORS) which includes:

- Visits to facilities,
- Complaints,
- Consultations;
- Training and other activities.

#### **Contents:**

- [Introduction: NORS Revisions](#)
- [Table 1: NORS Parts A, B and C - Case and complaint codes, values, and definitions](#)
- [Table 2: Complaint codes and definitions](#)

- [Table 3: State Program Information](#)
- [Crosswalk A: NORS Overview](#)
- [Crosswalk B: Complaint Codes \(Old NORS to Revised NORS\)](#)
- [Revised NORS Training Materials](#)
- [Revised NORS Training Materials](#)

### **Part I Revised NORS Training Materials**

- [Revised NORS Training Part I: Basic Principles \(black and white version\)](#)
- [Revised NORS Training Part I: Quiz \(black and white version\)](#)
- [Revised NORS Training Part I: Quiz Answer Sheet \(black and white version\)](#)
- [Table 1: NORS Parts A, B and C - Case and complaint codes, values, and definitions](#)

### **Part II Revised NORS Training Materials**

- [Revised NORS Training Part II: Complaint Coding Basic Principles \(black and white version\)](#)
- [Revised NORS Training Part II: Complaint Coding Quiz \(black and white version\)](#)
- [Revised NORS Training Part II: Complaint Coding Quiz Answer Sheet \(black and white version\)](#)
- [Revised NORS Training Part II: Complaint Coding Beyond the Basics Quiz \(black and white version\)](#)
- [Revised NORS Training Part II: Complaint Coding Beyond the Basics Quiz Answer Sheet \(black and white version\)](#)
- [NORS Table 2: Complaint codes and definitions](#)

### **Part III Revised NORS Training Materials**

- [Revised NORS Training Part III: Verification, Disposition, Referral, and Closing Cases Basic Principles \(black and white version\)](#)
- [Revised NORS Training Part III: Verification, Disposition, Referral, and Closing Cases - Closing the Case \(black and white version\)](#)
- [Revised NORS Training Part III: Verification, Disposition, Referral, and Closing Cases Quiz \(black and white version\)](#)

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- [Revised NORS Training Part III: Verification, Disposition, Referral, and Closing Cases Quiz Answer Sheet \(black and white version\)](#)
- [Table 1: NORS Parts A, B and C - Case and complaint codes, values, and definitions](#)
- [Table 2: Complaint codes and definitions](#)

# **Attachment A**

## **Conflict of Interest Declaration**

**45 CFR 1324**

## LONG-TERM CARE OMBUDSMAN CONFLICT OF INTEREST STATEMENT

A certified Long-Term Care (LTC) Ombudsman is a representative of the Office of the State Long-Term Care Ombudsman (OSLTCO). The long-term care ombudsmen must abide by strict conflict of interest standards. Any real or perceived conflict of interest erodes the credibility of the program. Any indication of partiality or self-interest by ombudsmen will weaken our ability to find solutions and help residents have a better quality of life.

To ensure compliance with the laws and regulations governing the ombudsman program, it is necessary that all ombudsmen understand and acknowledge any possible conflict of interest.

All possible conflicts of interest should be declared and recorded. Some minor conflicts can be eliminated or appropriately remedied by the Office of the State Long-Term Care Ombudsman. Most conflicts, however, exclude participation in the ombudsman program or serving as an ombudsman in a particular long-term care facility. Complete the following document to identify if any conflict(s) exist.

### Conflict of Interest

Involvement in the licensing or certification of a LTC facility or provision of a LTC service, including solicitation of employment by myself or a member of my immediate family (which is defined as a member of my household or a relative with whom there is a close personal or significant financial relationship)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed LTC facility or LTC service by myself or a member of my immediate family	<input type="checkbox"/> No <input type="checkbox"/> Yes
Employment or solicitation of employment of myself or a member of my immediate family by a LTC facility; participation in the management of a LTC facility by myself or a member of my immediate family	<input type="checkbox"/> No <input type="checkbox"/> Yes

Receipt of, or right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a LTC facility by myself or a member of my immediate family	<input type="checkbox"/> No <input type="checkbox"/> Yes
Accepting any gifts or gratuities, including meals, from a LTC facility or resident or resident representative or being named as the beneficiary of an estate, will, or trust of resident, or resident representative	<input type="checkbox"/> No <input type="checkbox"/> Yes
Accepting money or any other consideration from anyone other than the provider agency or other entity designated by the OSLTCO for the performance of an act in the regular course of LTC ombudsman duties	<input type="checkbox"/> No <input type="checkbox"/> Yes
Provision of services with conflicting responsibilities while serving as a LTC Ombudsman, such as adult protective services; discharge planning; serving as guardian, agent under power of attorney or other surrogate decision-maker for LTC residents in the service area	<input type="checkbox"/> No <input type="checkbox"/> Yes
Participation in pre-admission screening or case management for LTC residents	<input type="checkbox"/> No <input type="checkbox"/> Yes
Serving residents of a facility in which an immediate family member resides	<input type="checkbox"/> No <input type="checkbox"/> Yes
Participation in an activity that negatively impacts my ability to serve residents or are likely to create a perception that my interest is other than as a resident advocate.	<input type="checkbox"/> No <input type="checkbox"/> Yes

#### ACTUAL OR POTENTIAL ORGANIZATIONAL CONFLICTS OF INTEREST DISCLOSURE

If you answered “yes” to any of the questions above, provide the identified conflict(s) of interest along with your procedures to remedy/remove them. You are welcome to add additional pages if necessary. If ombudsman has identified a conflict of interest, notify the SLTCO ASAP to seek a resolution. If no conflicts were identified, please put non-applicable (N/A) in the boxes.



Identified Conflict of Interest:

Remedy or Removal Action(s):


I have read the above and affirm that my service as an ombudsman is in compliance with the stated "conflict of interest" standard. I understand any false information in the above statement may result in my decertification from the State of Idaho Long-Term Care Ombudsman Program.

\_\_\_\_\_  
Signature, Certified Long Term Care Ombudsman

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name/Title

\_\_\_\_\_  
Signature, State Long-Term Care Ombudsman

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name/Title

# **Attachment B**

## **Assisted Living Resident Rights**

**Idaho Code 39-3316**

# Assisted Living Residents Rights

## A. Purpose

The purpose of assisted living residents' rights is to safeguard and promote dignity, choice, and self-determination of residents in assisted living homes. To protect civil, personal, and privacy rights, the right to information, rights related to health care, due process, life in the assisted living home, and the handling of personal finances.

## B. Rights

Assisted living residents' rights are set out at IC 39-3316 as follows:

TITLE 39  
HEALTH AND SAFETY  
CHAPTER 33

IDAHO RESIDENTIAL CARE OR ASSISTED LIVING ACT

39-3316. RESIDENT RIGHTS. A residential care or assisted living facility must protect and promote the rights of each resident, including each of the following rights:

(1) Resident records. Each facility must maintain and keep current a record of the following information on each resident:

(a) A copy of the resident's current negotiated service agreement and physician's order.

(b) Written acknowledgement that the resident has received copies of the rights.

(c) A record of all personal property and funds which the resident has entrusted to the facility, including copies of receipts for the property.

(d) Information about any specific health problems of the resident which may be useful in a medical emergency.

(e) The name, address and telephone number of an individual identified by the resident who should be contacted in the event of an emergency or death of the resident.

(f) Any other health-related, emergency, or pertinent information which the resident requests the facility to keep on record.

(g) The current admission agreement between the resident and the facility.

(2) Privacy. Each resident must be assured the right to privacy with regard to accommodations, medical and other treatment, written and telephone communications, visits, and meetings of family and resident groups.

(3) Humane care and environment (dignity and respect).

(a) Each resident shall have the right to humane care and a humane environment, including the following:

(i) The right to a diet which is consistent with any religious or health-related restrictions.

(ii) The right to refuse a restricted diet.

(iii) The right to a safe and sanitary living environment.

(b) Each resident shall have the right to be treated with dignity and respect, including:

- (i) The right to be treated in a courteous manner by staff.
  - (ii) The right to receive a response from the facility to any request of the resident within a reasonable time.
  - (iii) The right to be communicated with, orally and/or in writing, in a language they understand.
- (4) Personal possessions. Each resident shall have the right to:
  - (a) Wear his own clothing.
  - (b) Determine his own dress or hair style.
  - (c) Retain and use his own personal property in his own living area so as to maintain individuality and personal dignity.
  - (d) Be provided a separate storage area in his own living area and at least one (1) locked cabinet or drawer for keeping personal property.
- (5) Personal funds. Residents whose board and care is paid for by public assistance shall retain, for their personal use, the difference between their total income and the applicable board and care allowance established by department rules.
  - (a) A facility shall not require a resident to deposit his personal funds with the facility.
  - (b) Once the facility accepts the written authorization of the resident, it must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.
- (6) Management of personal funds. Upon a facility's acceptance of written authorization of a resident, the facility must manage and account for the personal funds of the resident deposited with the facility as follows:
  - (a) The facility must deposit any amount of a resident's personal funds in excess of five (5) times the personal needs allowance in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts and credit all interest earned on such separate account to such account. The facility must maintain any other personal funds in a noninterest-bearing account or petty cash fund.
  - (b) The facility must assure a full and complete separate accounting of each resident's personal funds, maintain a written record of all financial transactions involving each resident's personal funds deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.
  - (c) Upon the death of a resident with such an account, the facility must promptly convey the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate. For clients of the department, the remaining balance of funds shall be refunded to the department.
- (7) Access and visitation rights. Each facility must permit:
  - (a) Immediate access to any resident by any representative of the department, by the state ombudsman for the elderly or his designees, or by the resident's individual physician.
  - (b) Immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives.
  - (c) Immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident.

(d) Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(8) Employment. Each resident shall have the right to refuse to perform services for the facility except as contracted for by the resident and the administrator of the facility. If the resident is hired by the facility to perform services as an employee of the facility, the wage paid to the resident shall be consistent with state and federal law.

(9) Confidentiality. Each resident shall have the right to confidentiality of personal and clinical records.

(10) Freedom from abuse, neglect, and restraints. Each resident shall have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical or chemical restraints.

(11) Freedom of religion. Each resident shall have the right to practice the religion of his choice or to abstain from religious practice. Residents shall also be free from the imposition of the religious practices of others.

(12) Control and receipt of health-related services. Each resident shall have the right to control his receipt of health-related services, including:

(a) The right to retain the services of his personal physician, dentist and other health care professionals.

(b) The right to select the pharmacy or pharmacist of their choice so long as it meets the statute and rules governing residential care or assisted living and the policies and procedures of the residential care or assisted living facility.

(c) The right to confidentiality and privacy concerning his medical or dental condition and treatment.

(d) The right to refuse medical services based on informed decision making. Refusal of treatment does not relieve the facility of its obligations under this chapter.

(13) Grievances. Each resident shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(14) Participation in resident and family groups. Each resident shall have the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(15) Participation in other activities. Each resident shall have the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(16) Examination of survey results. Each resident shall have the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the department with respect to the facility and any plan of correction in effect with respect to the facility.

(17) Access by advocates and representatives. A residential care or assisted living facility shall permit advocates and representatives of community legal services programs, whose purposes include rendering assistance without charge to residents, to have access to the facility at reasonable times in order to:

(a) Visit, talk with, and make personal, social and legal services available to all residents.

(b) Inform residents of their rights and entitlements, and their corresponding obligations, under state, federal and local laws by distribution of educational materials and discussion in groups and with individuals.

(c) Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance and social security benefits, and in all other matters in which residents are aggrieved, which may be provided individually, or in a group basis, and may include organizational activity, counseling and litigation.

(d) Engage in all other methods of assisting, advising and representing residents so as to extend to them the full enjoyment of their rights.

(e) Communicate privately and without restrictions with any resident who consents to the communication.

(f) Observe all common areas of the facility.

(18) Access by protection and advocacy system. A residential care or assisted living facility shall permit advocates and representatives of the protection and advocacy system designated by the governor pursuant to 42 U.S.C. Section 15043 and 42 U.S.C. section 10801 et seq., access to residents, facilities and records in accordance with applicable federal statutes and regulations.

(19) Access by the long-term care ombudsman. A residential care or assisted living facility shall permit advocates and representatives of the long-term care ombudsman program pursuant to 42 U.S.C. section 3058, section 67-5009, Idaho Code, and IDAPA 15.01.03, rules of the office on aging, access to residents, facilities and records in accordance with applicable federal and state law, rules and regulations.

The Idaho Code is made available on the Internet by the Idaho Legislature as a public service.

# **Attachment C**

## **Detrimental Effects of Physical and Chemical Restraints**

Developed by Sarah Greene Burger, National Consumer Voice for Quality Long Term Care

## Detrimental Effects of Physical and Chemical Restraints

*Developed by Sarah Greene Burger, National Consumer Voice for Quality Long Term Care*

**PR = physical restraint CR = chemical restraint**

SKIN	
<b>Effect:</b>	Bruising, cuts, redness (PR)
<b>Cause:</b>	Resident struggles against restraint. Incorrectly applied restraint or improper size or type of restraint.
<b>Prevention:</b>	Do not use restraint. Use alternative methods. Apply restraint correctly according to manufacturer's direction and monitor frequently. Apply restraint for short periods only.
<b>Effect:</b>	Pressure sores (PR/CR)
<b>Cause:</b>	Resident in one position too long. Studies show twice the number of pressure sores in restrained residents.
<b>Prevention:</b>	Release, exercise, at least every two hours, more often if necessary. Use alternative methods.



## PSYCHOLOGICAL

**Effect:** Panic/anxious expression/combative/increased confusion (PR/CR)

**Cause:** Frightened by PR. Does not like restraints. Does not understand why they are being used. Paradoxical reaction to a psychoactive drug; that is, it has the opposite effect intended.

**Prevention:** Use alternative methods. Use CR and PR for short periods only. Use different drug/lower dose/no drug.

**Effect:** Lethargy/depression/decreased social interaction (PR/CR)

**Cause:** Person gives up when restrained; withdraws; broken spirit. Staff ignores restrained resident. Drug is given in too large a dose.

**Prevention:** Use alternative methods. Increase opportunity to socialize. Be sure there is frequent staff interaction. Decrease time restraint is used. Decrease drug dose or change drugs.

**Effect:** Screaming/yelling/calling out (CR/PR)

**Cause:** Fear caused by restraint. Resident wants it removed. Loneliness. Unmet need such as pain, hunger, thirst, need to toilet.

**Prevention:** Use alternative options; identify and meet needs; comfort.

## GASTRO-INTESTINAL/GENITO-URINARY

**Effect:** Decrease in appetite/weight loss/sunken cheeks/sores around mouth (CR/PR)

**Cause:** Broken spirit/not interested in life. Discomfort of

**Effect:** DEHYDRATION: Dry skin/dry mouth/sunken eyes/fever/acute confusion (CR/PR) restraint/preoccupation with discomfort. No activity to work up appetite, too drowsy from drug to eat.

**Prevention:** Use alternative methods. Release, exercise, at least every two hours. Decrease drug dose.

**Cause:** Cannot reach water. Too drowsy to drink. Too depressed to drink. Does not recognize decreased sense of thirst.

**Prevention:** Use alternative methods. Leave water within reach at all times. Offer fluids/encourage drinking between meals and at meals.

**Effect:** URINARY RETENTION: Distended lower belly / complains of needing to go to bathroom / dribbles when toileted instead of good stream / presence of catheter with no other apparent cause (CR)

**Cause:** Many psychoactive drugs affect ability to release urine.

**Prevention:** Discontinue drug. Use alternative methods. Use alternative drug. Discontinue catheter use.

**Effect:** INCONTINENCE: Wet/complains of not being taken to bathroom/agitation, especially for resident with dementia/presence of catheter for no other apparent reason (CR/PR)

## GASTRO-INTESTINAL/GENITO-URINARY (Cont'd)

**Cause:** Not taken to bathroom. Toileting done according to facility rather than individual pattern. Drug action may cause incontinence.

**Prevention:** Release; toilet; exercise every two hours, or more if necessary. Use alternative methods. Discontinue drug.

**Effect:** URINARY TRACT INFECTIONS: Pain and frequency of urination; fever (CR/PR)

**Cause:** Catheter use, not voiding regularly, low fluid intake

**Prevention:** Toilet to avoid incontinence; increase fluid intake; use alternative methods.

**Effect:** CONSTIPATION/IMPACTION: Resident complains of stomach ache/constipation; restlessness; decreased appetite; confusion; preoccupied with bowels (CR/PR)

**Cause:** Lack of activity; inability to get enough fluids; not taken to bathroom according to lifelong bowel pattern.

**Prevention:** Release; exercise; toilet every two hours, or more often if necessary. Toilet according to lifelong pattern. Offer fluids between meals and at meals. Leave water within reach. Use alternative methods.

## RESPIRATORY

**Effect:** Resident complains that chest feels tight; says "can't breathe"; appears anxious (CR/PR)

**Cause:** Chest/vest restraint is too tight. Resident fears restraint and has anxiety attack. Lack of movement.

**Prevention:** Use alternative methods. Loosen restraint. Decrease use of drugs. Exercise every two hours, or more often if necessary.

**Effect:** Pneumonia; acute confusion / shortness of breath / chest pain (CR/PR)

**Cause:** Lack of movement allows secretions to pool; decreases efficiency of lungs, with decreased oxygen exchange and increased confusion. Shortness of breath when active.

**Prevention:** Same as above.

**Effect:** Death (PR)

**Cause:** Incorrectly applied restraint leads to death by strangulation.

**Prevention:** Apply restraint correctly. Use alternative methods.

## CARDIOVASCULAR

- Effect:** Death
- Cause:** Cardiovascular stress response as fearful resident struggles to be free from restraint.
- Prevention:** Use alternative methods.

## MUSCULO-SKELETON

- Effect:** Decrease in mobility such as inability to walk or move own wheelchair. Wasting of muscles over time. Contractures in extremities recognized by hands in fists, bent elbows, knees bent toward chest and moved, if at all, only with difficulty and pain. Increased fractures. (CR/PR)
- Cause:** Prolonged inactivity causes loss of muscle in all ages, so that the person gradually loses ability to use muscles. Bone loss results in increased fracture risk.
- Prevention:** Use alternative methods: physical therapy, release, or weight-bearing exercise every two hours, or more often if necessary. Include range of motion exercises; fit chair to individual; use cushions, wedges, and pillows for comfort.

## NERVOUS SYSTEM

- Effect:** Complains of tension or exhibits signs of tension (PR)
- Cause:** Restraints are not relaxing; stressful from having movement restricted.
- Prevention:** Use alternative methods. Use restraints for very short periods. Discontinue drug or lower dose. Use alternative drug without that particular side effect.
- Effect:** Tardive dyskinesia: repetitive movement of head, tongue, hands, and feet (CR)
- Cause:** Some types of chemical restraint. Haldol commonly has this effect, which is irreversible.
- Prevention:** Use lowest drug dose for shortest period. Keep in mind the general rule of thumb: one-half dose for elderly; one-fourth dose for elderly with dementia. (Of course, there are exceptions to this.) Note that continuous long term drug use is seldom necessary.
- Effect:** Coma/death (CR)
- Cause:** Too large a dose of psychoactive drug.
- Prevention:** Use small doses for short periods.

# Attachment D

## Assessment and Care Planning: The Key To Good Care

### A Guide for Nursing Home Residents and Their Families

Adapted from *Using Resident Assessment and Care Planning as Advocacy Tools*  
Sara S. Hunt & Sarah G. Burger, National Citizens' Coalition for Nursing Home Reform

## **Assessment and Care Planning: The Key To Good Care**

### **Why do you need to know about assessment and care planning?**

Every person in a nursing home has a right to good care, under the law. The law says the home must help people "attain or maintain" their highest level of well-being - physically, mentally and emotionally. To give good care, staff must assess each resident and plan care to support each person's life-long patterns, current interests, strengths, and needs. Resident and family involvement in care planning gives staff information they need to make sure residents get good care.

### **What is a resident assessment?**

Assessments gather information about how well residents can take care of themselves and when they need help in "functional abilities" -- how well they can walk, talk, eat, dress, bathe, see, hear, communicate, understand and remember. Staff also asks about residents' habits, activities and relationships so they can help residents live more comfortably and feel more at home.

The assessment helps staff look for what is causing a problem. For instance, poor balance could be caused by medications, sitting too much, weak muscles, poor fitting shoes, a urinary infection or an ear ache. Staff must know the cause in order to give treatment.

### **What is a plan of care?**

A plan of care is a strategy for how the staff will help a resident. It says what each staff person will do and when it will happen (for instance -- the nursing assistant will help Mrs. Jones walk to each meal to build her strength.) Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel like they meet their needs and must be comfortable with them. Care plans can address any medical or non-medical problem (example: incompatibility with a roommate).

### **What is a care planning conference?**

A care planning conference is a meeting where staff and residents/families talk about life in the facility -- meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs. Residents/families can bring up problems, ask questions, or offer information to help staff provide care. All staff who work with a resident should be involved -- nursing assistants, nurse, physician, social worker, activities staff, dietician, occupational and physical therapists.

### **When are care planning conferences held?**

Care planning meetings must occur every three months, and whenever there is a big change in a resident's physical or mental health that might require a change in care. The care plan must be done within 7 days after an assessment. Assessments must be done within 14 days of



admission and at least once a year, with reviews every three months and when there is a significant change in a resident's condition.

**What should you talk about at the meeting?**

Talk about what you need, how you feel; ask questions about care and the daily routine, about food, activities, interests, staff, personal care, medications, how well you get around. Staff must talk to you about treatment decisions, such as medications and restraints, and can only do what you agree to. You may have to be persistent about your concerns and choices. For help with problems, contact your local long term care ombudsman, advocacy group or others listed on the next page.

## **How Residents and their Families can participate in Care Planning**

Residents have the right to make choices about care, services, daily schedule and life in the facility, and to be involved in the care planning meeting. Participating is the only way to be heard.

***Before the meeting:***

- Tell staff how you feel, your concerns, what help you need or questions you have; plan your agenda of questions, needs, problems and goals for yourself and your care.
- Know, or ask your doctor or the staff, about your condition, care and treatment.
- Ask staff to hold the meeting when your family can come, if you want them there.

***During the meeting:***

- Discuss options for treatment and for meeting your needs and preferences. Ask questions if you need terms or procedures explained to you.
- Be sure you understand and agree with the care plan and feel it meets your needs. Ask for a copy of your care plan; ask with whom to talk to if you need changes in it.

***After the meeting:***

- See how your care plan is followed; talk with nurse aides, other staff or the doctor about it.

**Families**

- Support your relative's agenda, choices and participation in the meeting.
- Even if your relative has dementia, involve her/him in care planning as much as possible. Always assume that she/he may understand and communicate at some level. Help the staff find ways to communicate with and work with your loved one.
- Help watch how the care plan is working and talk with staff if questions arise.

***A Good Care Plan Should:***

- Be specific, individualized and written in common language that everyone can understand;

- Reflect residents' concerns and support residents' well-being, functioning and rights; not label residents' choices or needs as "problem behaviors";
- Use a multi-disciplinary team approach and use outside referrals as needed.
- Be re-evaluated and revised routinely. Watch for care plans that never change.

Prepared by the National Consumer Voice For Quality Long Term Care  
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# Glossary

*The major purpose of this glossary is to introduce the reader to common terminology used in work regarding institutional based long-term care.*

(Adapted from the Georgia Long Term Care Ombudsman Training Manual, developed by Leigh Anne Clark.)

## **Physical Conditions/Treatments/Services**

**Activities of Daily Living (ADL)-** Basic self-care activities, including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control and independent ambulation, which are widely used as a basis for assessing individual functional status.

**Acute Care-** Medical care designed to treat or cure disease or injury, usually within a limited time period. Acute care usually refers to physician and/or hospital services for less than 3 months.

**AIDS-** Acquired immune deficiency syndrome. A disease caused by a virus that can damage the brain and destroy the body's ability to fight off illness. AIDS by itself does not lead to death. But it allows other infections (such as pneumonia, cancer and other illnesses) to invade the body, and these diseases can lead to death. At the present time, there is no known cure for AIDS, and no vaccine that prevents the disease. There are three main ways the AIDS virus is spread: 1) having sex with an infected person, 2) sharing drug needles and syringes with users of heroin, cocaine and other illegal drugs, 3) babies can be born with the virus if the mother has been infected. It is extremely rare to contract AIDS from blood transfusion.

**Alzheimer's Disease-** A progressive, irreversible neurological disorder that affects an estimated 2.5 million American adults. It is the most common form of dementing illness. The disease, first described by Alois Alzheimer in 1906, knows no social or economic boundaries and affects men and women almost equally. Most victims are over 65; however, the disease can strike in the 40s and 50s. Symptoms include a gradual memory loss, decline in ability to perform routine tasks, impaired judgment, disorientation, personality change, difficulty in learning, and loss of language skills. There is variation in the rate of change from person to person.

The cause of Alzheimer's disease is not known and is currently receiving intensive scientific investigation. There is no single clinical test to identify the disease. Before diagnosis is made, other conditions must be excluded. These include reversible/treatable conditions such as depression, adverse drug reactions, metabolic changes, nutritional deficiencies and head injuries. While a thorough evaluation may provide a clinical diagnosis, confirmation of

Alzheimer's disease requires examination of brain tissue, which is usually performed at autopsy. (Source, the Alzheimer's Association)

**Ambulatory** - Ability to walk about.

**Ambulatory with Mechanical Assistance** – Ability to get about with the aid of a cane, crutch, brace, wheelchair or walker.

**Ambulatory with Assistance** - Ability to get about with the aid of another person.

**Analgesics** - A class of drugs used to reduce pain, such as Aspirin, Tylenol, Darvon, Codeine, Demerol, and Dilaudid.

**Ancillary Services** - Those services needed by a resident but not provided by a nursing home, such as podiatry or dentistry; costs which might not be included in the basic rate of the facility; sometimes used to refer to services other than nursing services, such as therapies, in which case they might be included in the basic rate, especially if they are part of the routine care for a person.

**Antacids** – Medication used to treat symptoms such as heartburn or upset stomach. Brands of medication include: Maalox and Mylanta.

**Anti-Anxiety Drugs/Medications** - A group of tranquilizing drugs which are supposed to have a calming or soothing, quieting or pacifying effect without depressing. Examples: Valium, Librium and Tranxene.

**Anti-Depressants** - A group of drugs that work to elevate moods, such as Ser-Ap-Es, Valium, Dalmane, Xanax, Zantac. (Zantac is used to treat stomach problems.)

**Anti-Hypertensives** - Drugs that lower the blood pressure, such as Serpasil.

**Anti-Inflammatory** - Drugs used to reduce inflammation like that occurring with arthritis, such as Aspirin, Indocin, Motrin/Ibuprofen.

**Anti-Psychotics** - A group of tranquilizing, mind-altering drugs which are more powerful than anti-anxiety drugs and work to reduce psychotic behaviors, such as Thorazine, Haldol, Mellaril and Navane and Compazine.

**Aphasia** - The inability to speak, usually caused by a stroke.

**Apnea** - The absence of breathing.

**Arteriosclerosis** – Thickening of the walls of the arterioles with loss of elasticity and contractility; the following terms are used in conjunction with this basic condition:

**Arteriosclerotic Brain Disease** - As the above, affects the brain (Also called Organic Brain Disease)

**Arteriosclerotic Heart Disease** - As the above, affects the heart

**Atherosclerosis** - Another word for Arteriosclerosis

**Heart Attack** - Common term used to describe sudden internal damage to the heart, often as a result of arteriosclerotic heart disease

**Stroke** - Occurs when blood supply to a part of the brain tissue is cut off, and, as a result, the nerve cells in that part of the brain cannot function. The effects may be severe or slight, temporary or permanent.

**Assessment Instruments (Tools)** - Testing forms and procedures to measure and evaluate individual functioning level. In long-term care, instruments used to measure the physical, mental, and psychosocial functioning of individuals. See Minimum Data Set and Resident Assessment.

**Assistive Device** - A tool, prosthesis, or adaptive equipment that helps an individual compensate for certain functional impairments, such as a hearing aid for hearing loss, glasses for vision loss, a cane to aid walking, or a universal cuff used to reduce the difficulty of eating.

**Atrophy** - The wasting away of an organ or body part. Atrophy can result when part of the body is not used, or to a lesser extent, in the normal course of aging.

**Basic Life Support** - The relatively simple resuscitative procedures used to restore and maintain breathing and circulation in a person who has experienced cardiac or respiratory arrest. Procedures include clearing the victim's airway, administering mouth-to-mouth resuscitation, and manually compressing the chest to stimulate the heart.

**Bed-Fast, Bed-Bound** - A condition in which one is confined to bed and not able to walk, sit, or move about independently.

**Bed Sore** - See Pressure Sore.

**Blood Pressure (BP)** - Measurement of the pressure of the blood in the arteries. (High blood pressure is called hypertension; low blood pressure is called hypotension.)

**Bowel and Bladder Training** - A program of retraining the bowel and/or bladder to its' regular function, to minimize or eliminate the inability to control these functions.

**Brain death** - Irreversible cessation of all function of the entire brain, including the brainstem, as evidenced by loss of all reflexes and electrical activity. Since 1970, many States have enacted legislation recognizing brain death as a criterion for determining death.

**Cancer** - A malignant growth of tissue. It may affect almost any organ or part of the body and spread through the blood stream.

**Cardiopulmonary Resuscitation (CPR)** - an array of interventions undertaken at the time of a cardiac or respiratory arrest to restore heartbeat and breathing. See Code Blue and Do Not Resuscitate.

**Care Plan** - A formal written plan of treatment and activities to be conducted by personnel of a long term care facility, home health agency, or other home care providers, hospital, adult day care center, or other health facility on behalf of a patient and used to evaluate that patient's needs and progress. Under OBRA 1987, care plans for nursing home residents must be formulated by a registered nurse in conjunction with a physician and other health care professionals to assure the "highest practicable physical, mental and psychosocial well-being of each resident." To the extent possible, care plans should be developed with participation from the residents and/or their representatives.

**Catheter** - A tube passed through the urethra into the bladder to drain urine. Other names are foley, foley catheter, and-in dwelling catheter. See also Urinary Catheter.

**Chair Bound** - Unable to get out of a chair without the help of another person.

**Chemical restraint** - Drugs which affect the central nervous system and are used to control mood, mental status or behavior of an individual.

**Chronic Condition** - A physical or mental illness or disorder characterized by a long duration (usually more than 3 months) or frequent recurrence.

**CHUKS (Chux)** - Trade name for a disposable pad which is soft on one side and waterproof on the other, used under incontinent persons or under draining areas of the body.

**Code Blue** - A summons/call for a resuscitation team for a patient whose heart has stopped beating or who has stopped breathing, usually used in a hospital setting.

**Cognitive** - Refers to the mental processes of comprehension, memory, judgment, and reasoning -- as opposed to emotional processes.

**Colostomy or Ileostomy** - An artificial opening in the abdomen for bowel movements, created surgically for serious intestinal problems. Colostomy or ileostomy care involves keeping the skin around the colostomy or ileostomy clean and free from sores. Care also involves emptying the bag regularly and keeping it free of odor.

**Coma** - A state of unconsciousness from which one cannot be aroused.

**Competency - Nurse Aide** - Required by OBRA 1987, a nursing facility must not permit a nurse aide (other than a nurse aide in a training or competency evaluation program) to provide services to a resident unless the aide has demonstrated competency to provide such services. Competency is determined by an evaluation/testing program developed by the state according to federal (CMS) guidelines. The aide must be competent in basic personal assistant nursing services such as turning, positioning, ambulation, cognitive impairments, residents' rights, etc. CMS is required to develop regulations to guide the states in the process of determination of competency.

**Continence** - Ability to control the passage of urine and feces. The opposite is incontinent, or inability to control the passage of urine or feces.

**Contracture** - Progressive stiffening in the muscles, tendons, and ligaments that surround the joints. Contractures tend to develop after a stroke or an injury when prolonged immobility has limited the movement of joints.

**Contraindication** - The inappropriateness of a form of treatment which would otherwise be desirable, due to a medical condition or other circumstance. For example, anti-psychotic drugs are contraindicated for patients who have very low blood pressure, because the drug may lower the blood pressure further.

**Custodial Care** - Care that attempts to maintain a person at an existing level and that does not involve any skilled rehabilitation or nursing services.

**Decubitus Ulcer**- See Pressure Sore.

**Dehydration** - Lack of adequate fluid in the body; a crucial factor in the health of older people. Confusion and lassitude are signs of dehydration. Weakness and lack of accessibility to fluids may interfere with the normal channels of maintaining fluid intake, resulting in a dehydration that can be measured by the increased blood urea nitrogen.

**Dementia** - The severe impairment of cognitive functions (thinking, memory, and personality). Of the older population, 5 to 6 percent have dementia. Alzheimer's disease causes approximately one-half of these cases, vascular disorders (multiple strokes) cause one-fourth, and the other dementias are caused by alcoholism, heart disease, infections, endocrine disorders, toxic reactions to medicines, and other rarer conditions. While impairment from Alzheimer's disease and vascular disorders is permanent, dementia caused by other conditions can usually be corrected.

**Dental Services** - Under OBRA 1987, each facility must provide directly or under agreements routine and emergency dental services to meet the needs of each resident.

**Diabetes** - A condition caused by the failure of the pancreas to secrete insulin characterized by excessive amounts of sugar in the blood and urine, and by thirst, hunger and loss of weight. An older person may have poor circulation, poor eyesight, or other debilitating complications from this disease.

**Diabetic Medications** - Replacement medications used to control diabetes such as Insulin, Orinase, and Diabinese.

**Diastolic pressure** - The pressure in the arteries when the heart is at rest.

**Dietary Services** - Under OBRA 1987, a facility is required to provide, directly or under arrangements, dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident.

**Disability** - The inability to perform an activity without assistance because of physical or mental impairment.

**Discharge** - A formal release from a hospital or a skilled nursing facility (SNF). Discharges include persons who died during their stay, or were transferred to another facility. OBRA 1987 contains specific rights regarding discharge of a resident from a nursing facility. A discharge can also occur when a resident is in an assisted living. See Orientation.

**Discharge Planning** - A centralized, coordinated program developed by a hospital or nursing home to ensure that each patient has a planned program for continuing or follow-up care once they leave the health facility, if needed.

**Disorientation** - Loss of one's cognition with respect to time, place and/or person; loss of sense of familiarity with one's surroundings. The opposite of disoriented is oriented.

**Diuretics** - A class of drugs given to help rid the body of excess fluid, often used on older persons with heart disease.

**Do Not Intubate (DNI) order** - A directive by a physician not to intubate a patient for mechanical ventilation. Other life-sustaining efforts short of intubation are not ruled out.

**Do Not Resuscitate (DNR) order** - A code/orders usually appearing in a patient's medical record directing that no CPR efforts are to be undertaken in the event of a cardiac or respiratory arrest.

**Drug Administration** - An act in which a single dose of a prescribed drug is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a properly labeled



container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper patient, and promptly recording the time and dose given.

**Drugs and Biologicals** - Substances in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies or as approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

**Edema** - Collection of fluids in tissues that result in swelling.

**Emphysema** - A condition in which the lungs become distended or ruptured.

**Enteral procedures** - Procedures in which nutritional formulas and water are introduced into the patient's stomach or intestine by means of a tube, such as a gastrostomy tube or nasogastric tube.

**Fluids Supplied Through Intravenous Tubes** - A resident who cannot eat enough food to stay healthy may receive nourishment in the form of fluids prescribed by a physician. These fluids are usually given by inserting a needle or a tube into a vein. Care involves making sure that the needle or tube stays free of germs and that it stays in the vein. Commonly called intravenous feeding (IV).

**Foley Catheter** - A catheter that is left in the urinary bladder so that urine drains continuously into a collection bag; an indwelling or retention catheter.

**Functional Dependence** - The inability to attend to one's own needs, including the basic activities of daily living. Dependence may result from the changes that accompany natural aging, or from a disease or related pathological condition. The opposite is functional independence.

**Functional Impairment** - Inability to perform basic self-care functions such as eating, dressing, and bathing, or instrumental activities of daily living, including home management activities such as cooking, shopping, or cleaning, because of a physical, mental, or emotional condition.

**Functionally Disabled** - A person with a physical or mental impairment that limits the individual's capacity for independent living.

**Gait belt** - A belt used by nursing personnel to assist a resident to transfer safely.

**Gastrointestinal Disease** – Disease to the stomach, colon, bowels, rectum i.e., peptic ulcer (ulcer of the stomach, colitis and diverticulitis (inflammatory disease of the large bowels).

**Gastrointestinal Medications** - Medications to relieve stomach problems, such as Tagamet and Donnatal.

**Gavage** - Tube feeding.

**Generic drug** - a medication sold by a chemical name rather than by a brand name.

**Geriatrics** - Refers to geriatric medicine. The term was originally coined in 1909 by the American physician, Ignaz Nascher, when he recognized a similarity between the fields of aging and pediatrics. Nascher is the founder of modern geriatrics in the U.S.

**Geri-chair** - A type of wheelchair which cannot be self-propelled. It must be pushed by someone else, has a high back, foot ledge and a removable dining tray. CMS includes a geri-chair in the definition for restraint.

**Glaucoma** - Disease of the eye. Results in atrophy of the optic nerve and blindness. An early sign of glaucoma is a complaint that lights appear to have halos around them. The condition is treatable by medications.

**Grab Bar** - Bars or railings placed around tubs, showers, and toilets to be used to steady one's self.

**Habilitation** - Programs and activities designed to help a client develop and maintain a maximum level of independence and self-sufficiency.

**Handicap** - A disadvantage resulting from a physical or mental impairment or disability that limits or prevents the fulfillment of a role that is normal (for that individual) in a given environment

**Hand Rails** - Railings placed on walls of halls to steady persons (a safety factor).

**Heart Medication** - Medicines which control the heartbeat, such as Digoxin, Lanoxin, and Digitalis.

**Heavy-Care Residents** - Residents of skilled or intermediate care facilities who require a great deal of attention for medical care, nursing care, and/or assistance with activities of daily living. Bed-fast or severely demented residents are examples of residents who require a higher level of care.

**Heimlich Maneuver** - A type of first aid administered to an individual who is choking.

**Hip Pinning** - A surgical procedure used to repair a broken hip; refers to the placing of a "Steel Plate" or "Pin" to hold splintered bone together.

**Hospice Care** - Care that addresses the physical, spiritual, emotional, psychological, social, financial, and legal needs of the dying patient and his/her family. A concept that refers to enhancing the dying person's quality of life. Hospice care is provided by an interdisciplinary team of professionals and volunteers in a variety of settings, both inpatient and at home, and includes bereavement care for the family. In 2009 Medicare will cover hospice care for up to two 90-day periods, followed by an unlimited number of 60 day periods. At the start of each period of care, your doctor must confirm that you are still terminally ill in order to continue the care.

**Hypertension** - High blood pressure, elevated pressure of the blood in the arteries. Left untreated, hypertension can increase the risk of heart attack, stroke, or kidney damage.

**Hyperthermia** - A condition in which the body temperature is so far above normal (e.g. above 104 F or 40 C) that irreversible damage or even death may result. Hyperthermia sometimes appears as heat stroke or heat exhaustion.

**Hypotension**- Low blood pressure, common in some older people when they stand up (Postural hypotension). Hypotension can be a common cause of falls in older individuals.

**Hypothermia** - A condition in which the body temperature drops so far below normal (e.g. below 95 F or 35 C) that irreversible damage or death may result. Anyone exposed to severe cold can develop accidental hypothermia; however, those at greatest risk are older persons who have chronic illnesses, suffer from temperature regulation defects, or cannot afford heating fuel.

**I and O** - Intake (of food and fluids) and output (of urine and feces).

**Impaction** - The prolonged retention and accumulation of fecal material in the rectum.

**Impairment** - A physical or mental abnormality that can be readily identified or diagnosed.

**Incontinence** - Lacking voluntary control over the bladder or bowel. In most people incontinence can be treated and controlled, if not cured. Specific changes in body function, often resulting from disease or the use of medications, are the cause of incontinence.

**Instrumental Activities of Daily Living (IADL)** - Home management and independent living activities such as cooking, cleaning, using a telephone, shopping, doing laundry, providing transportation, and managing money.

**Insulin** - A medication used to control diabetes.

**Isolation Techniques** - Methods to ensure that infection does not spread from one part of a resident's body to another; or from one resident to another.

**Life-Sustaining Technologies** - Drugs, medical devices, or procedures that can keep individuals alive who would otherwise die within a foreseeable, though usually uncertain, time.

**Medical Record** - Clinical documentation of a resident's health care, including, but not necessarily limited to, the medical, nursing, social and rehabilitative care provided to the resident.

**Metastasis** - The spread of cancer to other body parts from the original site.

**Mobility** - The capacity to negotiate one's physical surroundings or environment. Mobility is frequently assessed in terms pertaining to limitations (bedfast, housebound, ambulatory), and whether assistance is needed (a mechanical or assistive device and/or another human being).

**Nasal Gastric (NG) tube** - A tube passed through the nose to the stomach for the purpose of liquid feeding (called gastric or tube feeding).

**Ophthalmologist** - A physician specializing in the diagnosis and treatment of diseases, defects, and injuries of the eye.

**Organic Brain Syndrome (OBS)** - A disorder that may be acute or chronic, reversible or irreversible. Results in impaired mental function.

**Osteoporosis** - A disorder which causes a gradual decrease in the strength of bone tissues. Bones "thin out," becoming less dense or more porous, and thus lose strength.

**Palliative Care** - Refers to medical, surgical, and other interventions to alleviate suffering, discomfort, and dysfunction, whether physical or not, but not to cure or prolong life.

**Paraplegia** - Usually involves paralysis of the legs and often of other muscles up to the middle of the chest resulting from damage to the spine.

**Parenteral Nutritional Procedures** - Are procedures in which nutritional formulas and water are introduced into the patient's body by means other than the gastrointestinal tract.

**Parkinson's Disease** - A chronic, progressive neurological disorder characterized by shuffling gait, shaking of the upper extremities, loss of facial expression, and sometimes dementia in the later stages.

**Patient Assessment Computerized (PAC) System** - A standard resident assessment system developed and used by a private nursing home chain, the National Health Corporation, located in Tennessee.

**Patient Care Plan** - See Care Plan.

**Patient Care Profile** - A standard resident assessment system developed by William Thomas, a nursing home administrator in New Hampshire.

**Personal Care** - Services to assist individuals with activities of daily living, including bathing, grooming, and eating. The terms “custodial care,” “domiciliary care” and “residential care” are often used interchangeably with “personal care,” although “personal care” strictly defined may imply a somewhat higher level of service.

**Pharmacokinetics** - The way drugs act within the body.

**Polypharmacy** - the use of more than one psychoactive drug in treating a disease state.

**Post-Surgical Recovery** - Recovery from major surgery.

**Pre-Admission Screening** - An assessment process conducted prior to entry into a nursing home to determine a person's functional abilities, service needs, and service and living arrangement alternatives to institutional placement.

**Pressure Sore** - A sore that occurs when a person lies or sits in one position too long. Decreased circulation causes the tissue to break down into a sore. The sore may be a red spot on the skin surface or break down through the muscle and bone. Preventable except when a person is no longer taking nutrition. Also called a bedsore or decubitus ulcer.

**Privacy Curtain** - A curtain which can be pulled around a resident's bed affording privacy from other people in the room.

**P.R.N.** - A term/abbreviation used to indicate that a medication is given, or treatment performed only as the need arises.

**Prognosis** - An informed judgment about the likely course and probable outcome of a disease based on knowledge of the facts of a particular case. Usually a medical prediction.

**Psychosis (Psychotic)** - A mental disorder affecting the ability to think, respond emotionally, communicate, interpret reality, and behave appropriately under the demands of everyday life.

**Psychosomatic** - A physical disorder caused by emotional or psychogenic factors.

**Psychopharmacologic Drugs** - OBRA 1987, under Residents' Rights, restricts the use of psychopharmacologic drugs in Medicaid facilities. They may be administered only on the orders of a physician and only as part of a plan of care designed to eliminate or modify the symptoms for which the drugs are prescribed, and only if, at least annually an independent external consultant reviews the appropriateness of the drug plan of each resident receiving such drug. See Psychotropic Drugs.

**Psychotropic Drugs** - Drugs used in the treatment and control of mental illness.

**Reality Orientation** - A form of treatment aimed at promoting or maintaining an awareness of person, time and place.

**Rehabilitation** - Medical, health-related, social and/or vocational services performed by professional and technical personnel to help physically, mentally, or emotionally disabled persons attain and/or retain their functional capacity and independence. Rehabilitation therapy is especially useful to persons who have suffered from stroke, an injury, or disease by helping them recover the maximum use of the affected area(s) of the body.

**Rehabilitative Bowel and Bladder Training** - A program to help a resident to learn to control bowel and bladder functions.

**Resident Assessment** - A process of conducting a comprehensive assessment of a resident's functional and psychosocial health that is associated with the care to be provided or being provided. Under OBRA 1987, nursing home providers are required to conduct an assessment on every resident; to develop and follow a plan of care based on the assessment, and to review the assessment periodically. The assessment must be accurate, standardized, and reproducible and based on, a) the resident's capability to perform daily life functions and significant impairments in functional capacity, and b) a uniform minimum data set specified by the Department of Health and Human Services. Under law, penalties can be imposed if health care professionals in a facility do not produce an accurate assessment or if anyone falsifies an assessment. If a state determines under a survey that there has been a knowing and willful certification of false assessments, the state may require (for a period specified by the State) that resident assessments be conducted and certified by individuals who are independent of the facility and who are approved by the state.

**Respite Services** - Services provided on a short term basis to a dependent individual whose usual caregiver is temporarily unavailable or in need of a break from caregiving. Respite care is provided in a person's own home or in an alternative residence, including nursing homes.

**Restraints** - There are two types of restraints: physical and chemical. Because of growing recognition that restraints are overused and misused in some nursing homes, OBRA 1987 places restrictions on their use. In July of 1999, the CMS Guidance to Surveyors defines physical restraints as "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." A chemical restraint is "a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms." For a resident to make an informed choice about the use of restraints, the facility should explain to the resident the negative outcomes of restraint use such as: incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

**Risk Factors** - Characteristics, behaviors, circumstances, or environmental and other factors that are statistically associated with an increased likelihood of developing a given condition.

**Sedatives** - Drugs which provide calm and quiet to those in a state of nervous excitement. Sedatives include: Noctec, Nembutal, Seconal, Chloral Hydrate, and Phenobarbital.

**Self-Help, Self-Care** - A concept focused on an individual's ability to manage many of their own health problems when given sufficient instruction and appropriate medications. Examples of self-care include: bathing, dressing, toileting, and feeding oneself.

**Senescence** - Aging. The normal process of growing old, a process that occurs continuously at every biological level (chemical, cellular, tissue, organ systems, and to every organism).

**Senile Dementia** - An outdated term for dementia. Years ago, dementia was thought to be part of normal aging, but now we know that most people do not become demented as they grow older and that dementia, when it occurs, is due to some specific disease process. (Source: AGE WORDSDHHS)

**Senility** - Popularized layman's term used by doctors and the public alike to categorize the mental deterioration that may occur with diseases associated with aging. The term is outdated. See Dementia.

**Skin Breakdown** - When a resident remains in one position for a long period of time, his or her skin may be damaged. One of the first signals that this is happening is that reddened areas appear on the places where the resident has placed pressure from sitting in a chair or lying in bed. These reddened areas do not go away even after the positioning of the resident has been changed. If special care is not given, bed sores will develop. See Pressure Sore.

**Social Services** - OBRA 1987 requires that each facility provide either directly or under arrangements medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The services provided or must meet professional standards of quality. OBRA requires that each facility with more than 120 beds employ at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications).

**Somatize** - To involuntarily express emotional concerns as physical symptoms.

**Special Diet** - A diet which adds or subtracts certain nutrients in specified amounts or makes other modifications because of a medical condition. (Example, a pureed diet or a diabetic diet.)

**Suctioning**- A resident who is unable to cough up fluids or mucus in the air passages may have a tube inserted into the air passages to suck the fluids out. Care involves making sure that the fluids are removed as often as necessary and that the tube used is always free of germs.

**Sundowner's Syndrome** - The name given to displays of confusion by residents at dusk and after dark.

**Syncope** - Fainting. In older people this is a common cause of falling.

**Systolic pressure** - The amount of force it takes to pump blood out of the heart into the arterial circular.

**Tort** - A legal term which describes a wrong committed against another person of the person's property.

**T.P.R.** - Abbreviation for the measurement of temperature, pulse and respiration.

**Tracheotomy Care** - A resident who has difficulty breathing may have an operation which makes a breathing passage from the base of the neck into the lungs. This opening is called a tracheotomy. Care involves keeping the breathing passage clean and free from congestion.

**Tranquilizers** - A group of drugs which are used to calm, sooth, quiet or pacify, such as Thorazine, Valium and Librium. These drugs sometimes have the reverse effect in an older person.

**Transfer Trauma** - A trauma to a resident which can occur when the person is transferred from a facility (or a room) unexpectedly and/or unnecessarily, or without careful, proper preparation and procedures. Some states have established regulations to help prevent such trauma, which some experts associate with the deaths of transferred residents. \*

**Transfer** - This term has two meanings. First, the ability, or degree of assistance required, to move oneself from bed to chair, bed to toilet, chair to bath, etc. The ability to transfer is one element in an assessment of a resident's functional independence. Transfer is also used to describe moving from one section of a facility to another or from one facility to another. OBRA 1987 specifies a resident's right relating to transfer and discharge. See Orientation.

**Tube Feeding** - A method of feeding a resident who is unable to feed him/herself or who needs certain nutrients which are provided through tube feeding. See Gavage and N-G Tube Feeding.

**Twenty-four-Hour Nursing Services** - The facility provides 24-hour nursing services which are sufficient to meet total nursing needs, and which are in accordance with the patient care policies developed as according to regulations.

**Unit dose system** -A drug distribution and/or administration system which utilizes individually wrapped medicine doses.

**Urinary Catheter** - A tube inserted into the bladder to remove urine.

**Urinary Incontinence**- Inability to control urinary function.



**Urinary Tract Infection (U.T.I.)** - An infection in the urinary tract; patients with catheters are more susceptible to infections.

**Ventilator-dependent** - A patient who must rely on a ventilator for survival, whether for a short time, intermittently but frequently, or constantly.

**Vital Signs** - Temperature, pulse, respiration and blood pressure.

**Walker** - A lightweight frame held in front of a person to give stability in walking. It offers more stability than a cane.

**Select Organizations Pertinent to Institutional Care and Ombudsman Work**

**Administration for Community Living (ACL)** - The principal agency in the federal government responsible for administering the provisions of the Older Americans Act, which includes authority for the long-term care ombudsman program. This agency was previously the Administration on Aging.

**Aging Network** - A highly complex and differentiated system of federal, state and local agencies, organizations, and institutions responsible for serving and representing the needs of older people. The network is variously involved in service systems development, advocacy, planning, research, coordination, policy development, training and education, administration and direct service provision.

The core structures in the network include the U.S. Administration on Community Living (ACL), 57 State Units on Aging (SUA's), some 664 Area Agencies on Aging (AAAs), 721 state and local advisory councils, and thousands of service providers operating at the community level.

**American Association of Homes for the Aging, (AAHA)** - The trade association based in Washington, D.C., which represents, almost exclusively, the not-for-profit, voluntary nursing homes, continuing life care facilities and long term care housing.

**American College of Health Care Administrators** - A non-profit organization whose members are professional health care administrators, primarily of nursing homes. Most of its members work in facilities which are also members of either AAHA or AHCA.

**American Health Care Association, (AHCA)** - The trade association based in Washington, D.C., which represents a membership of nursing homes, the majority of which are proprietary, for-profit facilities.

**JCAHO - Joint Commission on the Accreditation of Healthcare Organizations.** A private agency headquartered in Chicago that primarily accredits hospitals but also nursing homes and other health care facilities and services. JCAHO accreditation qualifies (deems) hospitals-but not nursing homes-for federal Medicare and Medicaid certification; 13 states also deem JCAHO

accreditation for hospital licensure. Deemed facilities do not have to undergo a public inspection but are surveyed exclusively by JCAHO in surveys that are announced in advance and paid for by the facility.

**National Association of Area Agencies on Aging (NAAAA)** - A non-profit organization representing local planning and service units designated by the State Unit on Aging to plan and administer a program of comprehensive community services for the elders. AAA's can be private or nonprofit or a part of city and county government. Most ombudsman programs are sponsored by AAA's, directly or through contract.

**National Association of State Long Term Care Ombudsman Programs (NASOP)** – An organization of ombudsmen which provides information, assistance, and professional development support to its members (the 52 State Ombudsman programs). It provides a national voice for ombudsman participation in public policy advocacy for long term care facility residents and provides a channel for involvement in national efforts to strengthen the capacity of the ombudsman system.

**National Association of State Units on Aging (NASUA)** - A nonprofit organization which represents the state agencies which have authority to implement the Older Americans Act and operate the State Long Term Care Ombudsman Program, directly or through contract. The State Unit on Aging is designated by the governor and state legislature as the focal point for all matters related to the needs of older persons within the state. NASUA is the contractee of the Administration on Aging to operate The National Center for State Long Term Care Ombudsman Resources and the National Center for Long Term Care for community based long term care.

**National Long Term Care Ombudsman Resource Center** - Established under an Administration on Aging (AoA) contract in 1987, the Center provides services and educational materials to state ombudsmen and state units on aging. Its efforts are directed at building the capacity of the state ombudsman programs to handle their responsibilities as directed by the Older Americans Act. The National Association of State Units on Aging is under contract with AoA to develop and operate the Center, with a subcontract to the National Consumer Voice for Quality Long Term Care (formerly National Citizens' Coalition for Nursing Home Reform).

**National Consumer Voice for Quality Long Term Care (NCCNHR) – formerly known as National Citizens' Coalition for Nursing Home Reform-** A nonprofit organization which represents various organizations which work toward or support nursing home reform. Membership includes citizen groups, local and state ombudsman programs, legal services programs, providers, resident councils, resident coalitions and individual members including nursing home residents. NCCNHR is a subcontractee with the National Association of State Units on Aging, working cooperatively to operate the National Center for State Long Term Care Resources. Popularly called 'Nick-nur,' the organization also coordinates "Campaign for Quality Care," initiated in 1986 to strategize and coordinate activities directed at implementing the recommendations of the Institute of Medicine Report which led to the 1987 nursing home reform law. Over 50 national organizations participate in the Campaign.

**Social Security Administration** - The federal governmental agency encompassed within HHS which was created by the Social Security Act. The SSA administers programs throughout the United States by means of regional offices which are divided geographically by districts- These programs include Medicare, SSI, old age survivor's benefits, and disability.

**Veterans Administration (VA)** - Administers a nursing home program for veterans. The VA sponsors separate facilities and also provides benefits to veterans in selected facilities which contract with the VA. These facilities must meet standards established by VA, as well as other applicable standards.

### **Personnel Associated with Long-Term Care**

**Activity Director** - The person responsible for developing and maintaining the activities program in a nursing facility. OBRA 1987 requires the facility to provide, directly, or under arrangements as directed by a qualified professional the provision of an on-going program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident.

Assisted living facilities may or may not employ an activity director. They are required by IDAPA 16.03.22.151 to develop a policy and plan for planned recreational and other activities.

**Administrator** - A person licensed by the state to run a nursing home or assisted living facility. State requirements vary for both nursing homes and assisted living. (According to OBRA 1987, the Centers for Medicare and Medicaid Services established federal standards for nursing homes.)

**Allied Health Professionals** - Persons with special training in fields related to medicine such as medical social work and physical or occupational therapy. Allied health professionals work with physicians or other health professionals.

**Charge Nurse** - A registered nurse, or a licensed practical (vocational) nurse, is designated as charge nurse by the director of nursing services for each tour of duty and is responsible for supervision of the total nursing activities in the facility during each tour of duty. The director of nursing services may not serve as charge nurse in a facility with an average daily total occupancy of fewer than 60 patients. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific patients during each tour of duty, on the basis of staff qualifications, size and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.

**Dermatologist** - A physician specializing in the diagnosis and treatment of diseases, defects and injuries of the skin.

**Dietetic Service Supervisor** - A person who (1) is a qualified dietitian; or (2) is a graduate of a dietetic technician or dietetic assistant training program (corresponding or classroom), approved by the American Dietetic Association; or (3) is a graduate of a state-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or (4) has training and experience in food service supervision and management in a military service.

**Dietician** - A person who (1) is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or (2) has a baccalaureate degree with major studies in food and nutrition, dietetics, special diets or food service management, has 1 year of supervisory experience in the dietetic service of a health care industry, and participates annually in continuing dietetic education.

**Director of Nursing (DON)**- A full-time registered nurse (RN) who has in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff, and serves only one facility in this capacity. The DON is responsible for the development and maintenance of nursing service, objectives, standards of nursing practice, nursing policy and procedure manuals, scheduling of daily rounds to see all patients, methods for coordination of nursing services, for recommending the number and levels of nursing personnel to be employed, and nursing staff development.

**Geriatric Nurse Practitioner** - An R.N. educationally prepared to assume an expanding role in providing primary health care to older persons; one who possesses extensive knowledge of physical assessment and can manage stable chronic and minor acute diseases or conditions afflicting older persons; and who collaborates with other health professionals to provide optimal care to older persons.

**Geriatrician** - A physician who specializes in the diagnosis and treatment of diseases of aging and the aged.

**Home Health Aide** - A person who, under the supervision of a home health or social service agency, assists elderly, ill or disabled persons with household chores, bathing, personal care, and other daily living needs. Social service agency personnel are sometimes called personal care aides.

**Homemaker or Home Health Aide** - A person who is paid to help in the home with personal care, light housekeeping, meal preparation, and shopping. Some states and agencies make a distinction between homemaking (or housekeeping) services and personal care services.

**Homemaker Services** - Household services, such as shopping, cooking, and cleaning that can be part of a home care program. These services can be delivered in conjunction with home health care, as a separate service to those with functional limitations but who are otherwise healthy, or to replace or forestall the need for institutional care.

**Licensed Nursing Personnel** - Registered nurses or practical (vocational) nurses licensed by the state in which they practice.

**Licensed Practical Nurse (LPN)** - A nurse who is licensed according to state requirements, has graduated from an approved (usually nine months to one year) nursing program, and has passed an examination. LPNs provide personal care to patients under the supervision of a registered nurse. Training programs for LPNs are usually in trade, technical, or vocational schools, junior and community colleges, or hospitals. In California and Texas, the term used is licensed vocational nurse (LVN).

**Medical Director** - A physician who formulates and directs policy for medical care in the nursing home; required of all nursing facilities by law.

**Nurse Practitioner** - An R.N. qualified and specialty-trained to provide primary care, including primary healthcare in homes and in ambulatory care facilities. Nurse Practitioners generally function under the supervision of a physician, but not necessarily in her/his presence. They are usually salaried rather than paid on a fee-for-service basis.

**Nurse's Aide, Nursing Aide, Nursing Assistant, Orderly (male)** - People who, under the supervision of a licensed nurse, provide health care and assistance with activities of daily living to residents. Under OBRA 1987, nurse aides must be trained and evaluated to be competent before taking care of residents, unless they were eligible for a waiver or grandfathering of the requirements.

**Nursing Services** - Services provided by registered nurses, licensed nurses, and nursing assistants, under the direction or supervision of one or more registered nurses, licensed practical or vocational nurses. Under OBRA 1987, nursing facilities must provide nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable, physical, mental and psychosocial wellbeing of each resident. Additionally, it must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents and must use the services of a registered nurse for at least eight consecutive hours a day, seven days a week. This requirement may be waived under certain circumstances stipulated in the requirements for nursing facilities. If a waiver is granted, the State (under Medicaid) or the Secretary (under Medicare) must notify the state ombudsman and the facility must notify its residents and their immediate families.

**Occupational Therapist** - A person trained to conduct therapy to maintain, restore, or teach skills to improve manual dexterity and hand-eye coordination.

**Ombudsman** - A state representative or a representative of a public agency or a private nonprofit organization (which is not responsible for licensing or certifying long-term care facilities) who; (1) investigates and resolves complaints made by or on behalf of older individuals who are residents of long-term care facilities, rotating to administrative action that which may adversely affect the health, safety, welfare, and rights of such residents; (2)

monitors the development and implementation of federal, state, and local laws, regulations, and policies with respect to long-term care facilities in that state; (3) provides information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities; (4) provides for training volunteers and promotes the development of citizen organizations to participate in the ombudsman program; and (5) carries out such other activities as the State Commissioner on Aging deems appropriate.

**Physical Therapist** - A person trained to retain or restore functioning in the musculature of the arms, legs, hands, feet, back and neck through movement, exercises or treatments.

**Physician Assistants** - Persons who perform a number of tasks that were traditionally – performed by the physician (taking medical histories, making routine examinations) Training for physician assistants usually includes a specialized, 2-year program. Physician assistants always work under the supervision of a physician. Under OBRA 1987 a physician assistant can provide, after the initial visit provided by the physician, alternate personal visits.

**Physicians' Services** - OBRA 1987 requires that each nursing facility must require that the medical care of every resident be provided under the supervision of a physician; and provide for having a physician available to furnish necessary medical care in case of emergency. Under the supervision of a physician, required visits after the initial visit may alternate between the physician and by a physician assistants or nurse practitioner. See Physician Assistants and Nurse Practitioner.

**Podiatrist** - A physician specializing in the diagnosis and treatment of diseases, defects and injuries of the foot.

**Provider** - A term used in health and social service programs to refer to a supplier of health or social services; for example, a hospital, nursing home, home care agency, adult day care center, etc. Providers sign agreements with the government to meet the minimum standards of care stated in regulations for a given service or facility.

**Provider Agreement** - See Provider.

**Registered Nurse (RN)** - A professional, qualified nurse who has prepared for registered nurse licensure in any one of three kinds of programs: 1) Diploma program: A nurse who has graduated from a diploma program in a hospital school of nursing after studying 2-3 years, but no academic degree; 2) Associate degree: A nurse who has graduated from a two-year community college leading to an AD in nursing; and 3) Baccalaureate program: One who has graduated from a program, usually two-year nursing majors in four-year colleges and universities, leading to a baccalaureate degree in nursing. .

**Registry/Nurse Aide Registry** - OBRA 1987 requires that not later than March 1989, each State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency

evaluation program. The registry shall also include specific documented findings of resident neglect or abuse or misappropriation of resident property involving a nurse aide listed in the registry, as well as any brief statement of the individual disputing the findings. If states release information in the registry, they must disclose the aide's statement disputing the finding or a clear and accurate summary of the statement.

**Social Worker** - A person who is licensed, if applicable, by the state in which practicing, is a graduate of a school of social work accredited or approved by the Council on Social Work Education and has one year of social work experience in a health care setting. OBRA 1987 requires every nursing facility with more than 120 beds to employ a full-time professional social worker.

**Suppliers** - Persons or organizations other than doctors and health care facilities that furnish equipment or services covered by medical insurance under Medicare, for example, ambulance firms, independent laboratories, and organizations that rent or sell medical equipment are considered suppliers.

**Surveyor** - Agent of the state licensure office who inspects (surveys) nursing homes and assisted living facilities for the purposes of licensing or certification. Sometimes called an inspector.

**Vendor** - A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical services. A term common to the Medicaid program.

### **Miscellaneous**

**Abuse Registry** - Many states have a registry where abuse and neglect reports are maintained. While most state registries currently track victims of abuse, OBRA 1987 requires states to maintain registries that track persons found to have committed abuse, neglect, or misappropriation of residents' property who reside in a nursing home. (See Registry/Nurse Aide Registry, as required by OBRA 1987.)

Assisted living facilities are required to report allegations of abuse, neglect, or exploitation they are not required to maintain a registry.

**Accommodation of Needs** - A resident's right specified under OBRA 1987 for nursing home residents.

This right is also given to assisted living residents:

The right to: 1) receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be

endangered, and 2) to receive notice before the room or roommate of the resident in the facility is changed.

**Accredited Facility** - A hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), or a nursing home or home health agency accredited by the JCAHO. The federal government accepts (deems) for Medicare hospitals (but not nursing homes) which have been accredited by JCAHO.

**Adult Day Care** - The daily and regular provision of a range of services, provided under the auspices of a nursing home or assisted living facility or freestanding day care center, which may include health, medical, psychological, social, nutritional, and educational services that allow a person to function in the home or provide respite for caregivers.

**Adult Foster Care** - A community living alternative, serving primarily elders in family-like settings and providing assistance with activities of daily living. Programs receive financial support from state and local governments, usually with minimal regulations.

**Advance Directive** - A document in which a person gives advance directions about medical care or designates who should make medical decisions for the person should he or she lose decision-making capacity, or both. There are two types of advance directives: treatment directives and proxy directives. See also Durable Power of Attorney, Living Will.

**Age-Specific Rate** - The rate of occurrence of an event (for example, death, marriage, birth, illness) for a specified age group in a population.

**Aged** - Persons aged 65 and over, as defined by government benefit programs. Other programs use the age of 60 years and over.

**Aging of the Population** - The increasing proportion in the total population of older (age 65 and over) relative to younger (less than age 65) persons. It is generally measured in percentage distribution by age group, but also measured in median age, the age at which 50 percent of the population is older and 50 percent is younger.

**Alternative Disposition Plans (ADP)** - OBRA 1987 requires an Annual Resident Review for nursing home residents who are mentally ill or mentally retarded to determine if they are appropriately placed. The law required states to submit ADPs for people who are reviewed and found to need active treatment, but not nursing home care. They must be moved to an alternative setting and provided active treatment. All such transfers must be completed by April 1, 1994. The ADPs describe the state's plan for developing services or utilizing currently available settings to accommodate those who are moved and lay out the schedule for the transfers.

**Alternative Sanction** - See Sanction.



**Annual Survey** - The process of inspecting a health care facility for compliance with state licensing regulations and/or federal requirements for participation in Medicare and Medicaid.

**Appeals** - The process for challenging eligibility determinations under Medicaid, coverage determinations under Medicare, decisions by a facility to transfer a resident to another facility, or decisions about appropriate placement under PASARR.

**Appeals Council** - A group under the Social Security Administration which meets in Washington, D.C., and receives requests to review the decision of the hearing officer to deny benefits (the second step in the appeals processes of the Social Security Administration). The Appeals Council Review is the third and final “in house” appellant source.

**Assisted Living Homes** - Nonmedical facilities that provide room and board and some degree of protective supervision or oversight on a 24-hour basis. They are called by different names throughout the states such as board and care homes, group homes, residential care facilities, adult foster homes, domiciliary homes, personal care homes and rest homes. Total number in the U.S. is unknown. The operators of board and care homes are licensed by state agencies, each of which uses its own requirements for size (number of residents) and the services to be provided. There are no national standards. Not all homes are licensed or state regulated.

**Autonomy** - Derived from the Greek “autos” (self) and “nomos” (rule, governance, or law). In ethics, it is the principle that independent actions and choices of an individual should not be constrained by others.

**Ban on Admission** - An enforcement sanction which can be used by the state or federal government when a facility does not meet standards. The facility cannot receive any federal or state payment for any new residents it admits under Medicare and/or Medicaid, whichever applies. Under state licensure law, a State may have the authority to prohibit the facility from accepting any new private pay admissions, effectively stopping all new admissions to the facility. Under OBRA 1987, state and federal government must ban all payments for new admissions if a facility is out of compliance with requirements in three consecutive surveys or fails to correct deficiencies within three months of when they are cited.

**Bed-Hold** - When a facility holds a bed for a resident who has been transferred for hospitalization or therapeutic leave. As a right under OBRA 1987, a facility must provide written information to the resident and a family member or legal representative concerning the (1) provisions of the state plan regarding the period (if any) during which the resident will be permitted under the state plan to return and resume residence in the facility, and (2) the policies of the facility regarding such a period. Many states have a designated time period for which Medicaid will pay for a bed to be held. OBRA 1987 requires that if a bed hold period lapses, an individual has the right to return to the facility as soon as a semi-private bed becomes available.

**Bed-to-Population Ratio** - The number of beds certified for a specific health care service to every 1,000 persons in the group intended to use the service. For example, the number of SNF beds per 1,000 persons aged 65 and over.

**Case Management** - An inter-agency, standardized process designed to coordinate a range of services needed by vulnerable clients. It includes an objective assessment of client needs; the development of an individualized care plan based on a needs assessment that is goal oriented and time limited; arrangement of services; and reassessment, including monitoring and follow-up.

**Case Mix** - The combination of diagnoses, medical care, and social care needs present in the population (residents) of a health care facility.

**Certificate of Need (CON)** - A certificate issued by a government body to a health care provider who is proposing to construct, modify, or expand facilities, or to offer new or different types of health services. CON is intended to prevent duplication of services and over-bedding. The certificate signifies that the change has been approved. Once a federal requirement under Public Law 92-641, it is now an optional state program.

**Certification for Medicare** - A recommendation made by the state survey agency to the federal agency (CMS) regarding the compliance of providers with the federal regulations/requirements. A facility has to be licensed by the state before it can be certified by Medicare. Once certified, the facility can accept Medicare patients.

**Certified Family Home** – A home certified by the Department of Health and Welfare to provide care to one or two adults who are unable to reside on their own and require help with activities of daily living, protection and security.

**Civil Money Penalties** - enforcement sanction which a state agency or the federal government can apply to a nursing facility which has deficiencies. The facility is fined actual money, the amount of which increases based on the severity and repetition of the deficiency. Used as an alternative to closure of a facility. Authorized by OBRA 1987.

**Cohort** - A population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage. The most common cohort is the “birth cohorts,” a group of individuals born within a defined time period, usually a calendar year or a five-year interval.

**Commode** - A portable toilet used in a resident's room.

**Community-Based Services** - Those services that are provided through local agencies in order to maintain disabled individuals in the community. They may be provided in either the person's own home or in settings to which the client travels (e.g. adult day care program.)

**Co-morbidity** - The simultaneous occurrence of multiple medical conditions or diseases in a single person.

**Competency** - Resident- See Incompetent.

**Complaint Visit** - A visit made by the state survey agency staff, or an ombudsman, in response to a complaint made about the facility to the agency.

**Confidentiality** - A resident's right specified by OBRA 1987. The right to confidentiality of personal and clinical records. Also, a responsibility under the Older Americans Act for the ombudsman program. Under the OAA, the State Agency will establish procedure for appropriate access by the ombudsman to long-term care facilities and patients' records and ensure that the identity of any complainant or resident will not be disclosed without the written consent of such complainant or resident, or upon court order.

**Congregate Housing** - Multiple-unit housing with common dining room, shared common space, and services for those elders/handicapped who are not totally independent but who do not need institutional or continual nursing care.

**Conservatorship** – A Procedure whereby a competent, suitable person is appointed by the court to manage the financial affairs of another person called a ward. The conservator manages and protects the ward's assets and makes sure that the ward's bills are paid or the person dependent upon him will not receive proper support, care and welfare if the funds are not managed by someone else.

**Continuum of Care** - A comprehensive system of long-term care services and support systems in the community, as well as in institutions. Continuum includes: 1) community services such as senior centers; 2) in-home care such as home delivered meals, homemaker services, home health services, shopping assistance, personal care, chore services, and friendly visiting; 3) community-based services such as adult day care; 4) non-institutional housing arrangements such as congregate housing, shared housing, and board and care homes; and 5) nursing homes.

**Decertify/Terminate** - An enforcement sanction which a state agency or the federal government can apply to a nursing facility which has serious deficiencies. The certification may be revoked or suspended. A facility may be decertified upon recommendation or action by the state agency or independently by CMS after a "look-behind" survey. Normally a facility has 90 days to correct deficiencies or face decertification. If the facility's conditions pose "jeopardy" - an immediate and serious threat to the health and safety of residents, decertification may occur on a 'last track' of 23 days.

**Deficiencies** - The designation a surveyor makes on finding a nursing home out of compliance with requirements of participation in the Medicare and Medicaid programs, as specified by OBRA 1987 and the federal regulations implementing OBRA. Under OBRA 1987, each state is required to implement a program to measure and reduce inconsistency in the application of

survey results among surveyors. The Centers for Medicare and Medicaid Services has developed guidelines for determining deficiencies based on the severity and scope of surveyor findings.

The designation a surveyor makes, through violation of state statute and rule that an assisted living facility is out of compliance.

**Denial of Payment** - An enforcement sanction which can be used by a state agency or the federal government (CMS) when a facility has serious deficiencies. It decertifies the facility from Medicare and Medicaid often coming simultaneously with action by the state to take away a facility's license to operate. As a lesser penalty, a state or the federal government may deny payment only for new admissions but continue to make payments for current residents. See Ban on Admissions.

**Disaster Plans** - Written plans including step-by-step procedures or action to be taken in case of fire, explosion, flood, or other disaster.

**Disclosure** - Under OBRA 1987 each state must disclose, as public information, the results of inspections/surveys and facility certification, including statements of deficiencies and plans of correction. It must also disclose copies of cost reports filed by facilities and copies of statements of facility ownership. Each state must notify the state long term care ombudsman of the state's findings of noncompliance with any of the requirements of the law and decisions to take enforcement action. If a state finds that a facility has provided substandard quality of care, the state must notify: a) the attending physician of each resident with respect to which such finding is made, and b) the state board responsible for the licensing of the facility administrator. Each state must provide its state Medicaid fraud and abuse control unit with access to all information of the state agency responsible for surveys and certification. Additionally, each facility is required to have survey reports available in the facility for residents and others to review.

**Distinct Part Facility** - A nursing home that is certified by the state agency to provide either skilled or intermediate care in separate designated areas of the facility. Also used to refer to a part of a facility certified under Medicare or under Medicaid, separate from the rest of the facility.

**Domiciliary Care** – Type of care where room, board, and the provision of some assistance with daily living activities such as grooming, bathing, and eating is provided. The Veterans Administration offers a domiciliary type of care. Most states require a license for facilities offering this care.

**Dually Certified Facility** - A nursing home certified both for Medicare and Medicaid.

**Durable Power of Attorney** - An individual's written designation of another person to act on his or her behalf, when the designation is authorized by a state's durable power of attorney

statute. Under state law, a Power of Attorney terminates when the designating individual loses decision-making capacity, whereas a durable power of attorney does not. A DPA is one type of proxy directive. See Power of Attorney.

**Elements** - Pre-OBRA regulatory designation for subsections of the regulations which explain standards and conditions of participation. Under OBRA all regulations will be called. See Conditions of Participation and Standards of Participation.

**Emergency Power** – An alternative source of electrical power that can be used in case of a regular power failure.

**Enforcement** - See Sanction/Remedy.

**Equal Access to Quality Care** - Under OBRA 1987, a nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services for all individuals regardless of source of payment.

**Ethics Committee** - Consultative committee in a hospital or other institution whose role is to analyze ethical dilemmas and to advise and educate health care providers, patients, and families regarding difficult treatment decisions.

**Euthanasia** - An act intended to cause the merciful death of a person who is suffering from what is believed to be an incurable condition.

**Examination of Survey Results** - A nursing home resident's right specified in OBRA 1987 and also extended to assisted living residents as well as the general public. The right to, upon reasonable request, examine the results of the most recent nursing home survey conducted by CMS or a State, including the plan of correction.

**Extended Survey** - Under OBRA 1987, each facility which is found in a standard survey to have provided substandard care, shall be subject to an extended survey. CMS survey procedures direct that a survey is to be extended when the survey team observes poor outcomes of sufficient frequency and/or severity to indicate a deficiency under one or more of Level A requirements found in 483.10, Residents Rights'; 483.13, Resident Behavior and Facility Practices; 483.15, Quality of Life; and 483.25, Quality of Care. Under OBRA 1987, in an extended survey, the survey team shall review and identify the policies and procedures which produced substandard quality of care, including an expansion of the sample of residents, a review of the staffing, of in-service training, and, if appropriate, contracts with consultants. The extended survey must be conducted immediately after the standards survey (or, if not practical, not later than two weeks after the date of completion of the standard survey).

**Fast Track Decertification** - See Decertify/Termination.

**Fire Resistance Rating** - The time, in minutes or hours, where materials have withstood a fire exposure as established in accordance with test procedures of Standard Methods of Fire Test Building Construction and Material.

**Fire Safety Evaluating System** - A method of determining whether a facility, not of an approved construction type, can be given a waiver on the basis of points granted for existing safety features, such as sprinklers, fire walls, and additional exits.

**Follow-up Visit** - A brief return visit made by the state survey agency to a health care facility within 90 days of an annual survey in order to determine a facility's progress on correcting violations found by the survey agency during the annual survey.

**Free Choice** - A resident's right specified by OBRA 1987. The right to choose a personal attending physician, to be fully informed in advance about care and treatment to be fully informed in advance of any changes in care or treatment that may affect the resident's wellbeing, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

**Gatekeeper** - An agency or process which monitors and controls formal and informal services provided to an individual or group.

**Gerontology** - The study of aging from the broadest perspective. Gerontologists examine not only the clinical and biological aspects of aging but also psychosocial, economic, and historical conditions. The term was first used in 1903 to describe the biological study of senescence.

**Grievances** - A resident's right specified by OBRA 1987. The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

**Guardian** - A person appointed by a court to make various kinds of life decisions for a person who is incapacitated.

**Guardianship** - The legal relationship of guardian and ward. A guardian (of the person) may be appointed to care for an incapacitated person, (called ward), defined as: a person whose ability to receive and evaluate information or to communicate decisions is impaired to the extent that the person lacks the ability to provide the essential requirements for the person's physical health or safety without court-ordered assistance. A person cannot be made a guardian or a ward without a court action. Court can appoint a guardian only if a judge is satisfied by clear and convincing evidence that the person is "legally incapacitated."

**Hearing** - In reference to the Social Security Administration (SSA), a hearing is the second step in appeals process whereby an administrative law judge of the SSA hears the initial or reconsidered decision made by the SSA along with any new evidence and issues a decision.

**Highest practicable** - See Practicable.

**Home Care** - Medical, social, and supportive services provided in the home, usually intended to maintain independent functioning and avoid institutionalization.

**Home Health Agency (HHA)** - A public or private organization providing skilled nursing services, other therapeutic services and other assisting services in the patient's home, and which meets certain conditions to ensure the health and safety of the individuals who receive the services. A facility may be certified by Medicare and required to meet Medicare requirements.

**Home Health Care Services** - Services and items furnished to an individual by a home health agency or by others under arrangements made by such an agency. The services are furnished under a plan established and periodically reviewed by a physician and supervised by a licensed nurse. The services are provided on a visiting basis in an individual's home and may include: part-time or intermittent skilled nursing care; physical, occupational, or speech therapy, medical social services; medical supplies and appliances (other than drugs and biologicals); personal care services. \*

**Hospital-Based Facility** - A designated area of a hospital certified by the state to provide skilled and/or intermediate care.

**Immediate and Serious Threat** - Conditions in a nursing home which pose immediate jeopardy to the health and safety of residents and require swift action by the government. Under CMS procedures, states and the federal government must move for decertification of a facility from Medicare and Medicaid within 23 days, called last track decertification. Under OBRA 1987, states and the federal government also have the option to impose a temporary management on the facility, rather than to decertify it from the program. Whether it chooses to decertify or place a temporary manager in charge, the government must, under OBRA, take immediate action to remove the jeopardy and correct the deficiencies.

**ICF/IMR** - Intermediate care facility for the mentally retarded regulated by federal standard

**Incapacitated Adult**- A person whose ability to receive and evaluate information or to communicate decisions is impaired to the extent that the person lacks the ability to provide the essential requirements for the person's physical health or safety without court-ordered assistance.

**Incident Report** - A report usually written by a staff member that documents any unusual problem, incident, or other situation for which resident or staff member wishes to have follow-up action taken by appropriate administrative or supervisory personnel. Some states routinely review incident reports at the time of the survey.

**Incompetent** - A resident who cannot make decisions because of impairments in mental ability may be called incompetent. This is a legal term meaning a court has decided that the person cannot make and articulate rational decisions, but it is also used as a descriptive term. Under OBRA 1987, if a resident is adjudged incompetent under the laws of a state, the rights of the resident under Title 18 and 19 devolve upon, and to the extent judged necessary by a court of competent jurisdiction be exercised by, the person appointed under state law to act on the resident's behalf.

**Independent Assessor** - See Resident Assessment.

**Independent Professional Review** - See Inspection of Care.

**Informed consent** - A legal term that refers to a person's consent to a proposed medical intervention after being provided information deemed relevant to the decision. The information that is legally required include: diagnosis, nature and purpose of proposed intervention, risks and consequences of proposed treatment probability that the treatment will be successful, feasible treatment alternatives, and prognosis if the treatment is not given.

**Inspection** - A term often used in place of (or the same as) the word survey. Federal regulations use the word survey.

**Inspection of Care** - A regular program of medical review under Medicaid (including medical evaluation) by one or more medical review teams (composed of physicians or, registered nurses and other appropriate health and social service personnel) to determine (1) the care being provided in nursing facilities; (2) the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in the home (or institution); (3) the necessity and desirability of the continued placement of patients in the nursing home (or institution); and (4) the feasibility of meeting the patient's health care needs through alternative institutional or non-institutional services. OBRA 1987 abolishes the federal mandate for this program once Resident Assessment is in place; CMS made this effective December 31, 1990.

**Institutionalization** - Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period time or indefinitely.

**Intermediate Sanction** - A penalty short of termination of a facility's Medicaid or Medicare contract, which is imposed by states or the federal government against health care facilities found out of compliance with state or federal regulations. OBRA 1987 (P.L 100-203) requires both states and the federal government to develop sanctions. See Sanction/Remedy.



**Guidance to Surveyors** - Information prepared by the Centers for Medicare and Medicaid Services for surveyors which explains nursing facility regulations/requirements and guides surveyors in their evaluation of a facility's compliance with the requirements. It includes definitions of terms used in the regulations (such as “restraints” and “reasonable accommodation of individual needs”). It also provides probes, questions for surveyors to use in interviews with residents and staff, and observations to make to determine if there are any problems at the facility. The guidelines are contained in a document which also includes procedures surveyors are required to follow in the conduct of their inspections, including how to interview residents, what to observe, and how to analyze what they find. This document is CMS Transmittal 10, State Operations Manual.

**Justice**- Generally refers to fair and equal treatment. In ethics, it is the principle that one should act in such a manner that no one person or group bears a disproportionate share of benefits or burdens.

**Quality Indicators** - Measures of quality of care and quality of life which focus on care given to residents, the results (outcome) of such care, and the manner (process) in which the care is given, for example, use of certain drugs, and incidence of infections and decubiti. These are based on the resident assessment instrument.

**Legal Services Developer** -The legal professional designated by the State Unit on Aging to provide legal advice and representation to older individuals. The State Unit may either provide the service directly or contract for it. Services include counseling and representation on civil matters by a licensed attorney or trained paralegal, where permitted by law.

**Level of Care** - The amount of medical care and assistance with activities of daily living needed by individuals in a group.

**Licensure** - The granting of a state license to a facility/home which is found in an annual inspection to be in compliance with a set of state standards of staffing, cleanliness, maintenance of records, etc. All facilities above the minimum size must be licensed in order to operate. This minimum size varies from state to state but tends to be so small (e.g. two beds) that virtually all area homes will be included. A facility must be licensed by the state in order to be certified by Medicare or Medicaid.

**Life Expectancy** - A measure of the average remaining years of life at specified ages for different subgroups (for example, sex and race) of a population.

**Life Safety Code (LSC)** - Fire Safety Code: regulatory criteria established by the National Fire Protection Agency and used by the state health agency or fire marshal to determine whether a physical plant is structurally safe and adequately prepared against fire to protect residents.

**Living Will-** Document stating a person's desires related to the use of mechanical or heroic life support measures to maintain life when terminally ill and incapacitated/unable to express one's wishes.

**Long-Term Care** - A variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home, or the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies.

**Long-Term Care Facility** - Any nursing facility, assisted living home, adult care home, or similar institution regulated by a state.

**Look Behind Survey** - The federal Centers for Medicare and Medicaid Services is authorized to do a "look behind" survey after the state survey/inspection in order to determine the quality of the state survey of that facility. CMS can take action against a facility based on this survey. See also Validation Survey.

**Malpractice** - Negligence by a professional person.

**Minimum Data Set (MDS)** - Information to be utilized in the resident assessment system to be conducted for every nursing home resident, required by OBRA 1987.

**Monitoring** - An enforcement sanction authorized by OBRA 1987 that can be used by a state agency or the federal government (CMS) when a facility is not in compliance with the requirements of the law, or the state sees the need to monitor its continued compliance. States must maintain procedures and sufficient staff to monitor the nursing facility's delivery of care on-site, on a regular, as needed basis.

**Morbidity** – Ill health. The number of sick persons or cases of disease within a population during a specified time period.

**Negligence** - An act in which a responsible person fails to act in a reasonable and careful manner and thereby causes harm to another person or to the person's property. Some states have laws which define negligence as it pertains to a nursing home care. Under OBRA 1987, neglect (and/or abuse) by a nurse aide must be reported to a state registry. A state may not make a finding of neglect if it was caused by factors beyond an individual's control.

**Noncompliance** - When a facility does not meet the requirements, standards or regulations required by law.

**Notice of Rights** - A resident's right specified in OBRA 1987. A nursing facility must inform each resident, orally, and in writing at the time of admission to the facility: 1) of the resident's legal rights during the stay at the facility; 2) make available to each resident upon reasonable request, a written statement of such rights (which statement is updated upon changes in such

rights); 3) inform each resident who is entitled to medical assistance of the items and services that are included in the nursing facility services under the state plan. The resident must also be informed of those other items and services that the facility offers and for which the resident may be charged and the amount of the charge for such items and services. They must be notified of changes in the items and services in writing before or at the time of admission and periodically during their stay. Residents must also be notified of services available in the facility and of related charges for such services, including any charges for services not covered under title 19 or by the facility's basic per item charge.

**Nurse-Bed Ratio** - The number of full-time equivalent nursing personnel to the number of beds.

**Nursing Facility** - An institution, other than an acute care hospital that provides continuous nursing and other health-related, psychosocial, and personal services to patients who are not in an acute phase of illness but who primarily require continued care on an inpatient basis. Nursing homes are licensed and have an organized professional staff and permanent facilities, including inpatient beds.

**OBRA** - See Omnibus Budget Reconciliation Act.

**Older Americans Act (Public Law 89-73)** - A federal program, initially passed in 1965, to encourage the development of comprehensive planning and to coordinate the provision of services for elders, including nutrition, health, housing, employment, transportation, information, and referral. Eligibility for the direct services is extended to all people aged 60 or older, without regard to income, but services are targeted to those with greatest need. In 1978 Congress amended the law to include the requirement that each state develop and operate an ombudsman program.

**Omnibus Budget Reconciliation Act (OBRA), Public Law 100-203 (OBRA 1987)** - A full federal budget statute/law which contains the comprehensive Nursing Home Reform Law passed by Congress 12-21-87; signed by the President 12-22-87. The Social Security Act portion of OBRA - added new provisions in "Section C. Nursing Home Reform," including residents rights; quality of care; quality of life; resident assessment; nurse aide training; and PASARR. The law strengthened government survey and enforcement requirements and required DHHS-CMS to promulgate new requirements (regulations) for use by state survey agencies. The nursing home reform portion of the law is often popularly referred to as "OBRA" by people in the nursing home field, although OBRA technically contains the full federal budget proposal.

**Orientation** - A resident's right specified in OBRA 1987. A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

**Outcome Measurement** - An examination of the results of a service in order to determine the quality of the service provided. An "outcome" is an indicator of quality. The Centers for Medicare and Medicaid Services published final rules to define outcome as it relates to quality

of care and quality of life. CMS also published The Interpretive Guidelines in July 1999, which address how surveyors should analyze what they observe in the nursing home related to quality to determine if the outcomes represent violations of OBRA's requirements.

**Participation** - A resident's right specified in OBRA 1987. The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility. Also, the right to participate in social, religious, and community activities that do not interfere with the rights of other residents. Also means a facility's enrollment in the Medicare or Medicaid program, whereby it receives government payment in exchange for providing services in accordance with government regulations.

**PASARR** - See Pre-admission Screening and Annual Resident Review.

**Peer Review** - An evaluation by practicing physicians or other health professionals of the necessity, effectiveness and efficiency of services ordered or performed by other practicing physicians or members of the profession.

**Plan of Correction** - The form by which a facility documents its procedures and time frame for correcting violations of certification regulations cited by the state survey agency.

**Power of Attorney** - The simplest and least expensive legal device for authorizing one person to manage the affairs of another. In essence, it is a written agreement usually with a close relative, an attorney, a business associate or financial advisor, authorizing that person to sign documents and conduct transactions on the individual's behalf. The individual can delegate as much or as little power as desired and end the arrangement at any time. See Durable Power of Attorney.

**Practicable** - OBRA 1987 (P.L. 100-203) requires nursing facilities to attain or maintain the highest "practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." Dictionary definition of practicable: possible to practice or perform. CMS has defined highest practicable in its Interpretive Guidelines as "the highest level of functioning and well-being possible, limited by the individual's presenting functional status and potential for improvement reduced rate of functional decline. Highest practicable is determined through functional assessment and aggressive, competent addressing of the physical, mental or psychosocial needs of the individual."

**Pre-Admission Screening and Annual Resident Review (PASARR)** - Required by OBRA 1987 (P.L. 200-203). To divert individuals with serious mental illness or mental retardation (MI/MR), who do not need nursing home care, from nursing homes. As of October 1, 1988, state mental health authorities were required to have in effect a program for evaluating new admissions. By April 1, 1990, states must have completed a review of every MI/MR individual already residing in a nursing home and must then have a process to review such individuals annually. CMS regulations require both a Level One Identification Screen and an in-depth Level Two

evaluation. States are required to provide “specialized services” for persons who are screened and determined to need such treatment

**Privacy** - A resident's right specified by OBRA, 1987. The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

**Process Measurement** - The examination of methods of providing a service in order to evaluate the quality of the service provided.

**Proprietary Facility** - A facility that is operated for the purpose of making a profit. The facility pays taxes.

**Protection of Resident Funds** - A resident's right as specified in OBRA 1987. The facility may not require residents to deposit their personal funds with the facility. Upon the written authorization of the resident, the facility must hold, safeguard, and account for such personal funds under a system established and maintained by the facility. OBRA specifies the management responsibilities of the facility.

**Protocol** - Refers to the process by which surveyors monitor/survey facilities. CMS develops and publishes the survey protocol for the states to follow. Under OBRA 1987, the Secretary of DHHS must develop, test and validate a survey protocol for standard and extended surveys. The protocol must specify the survey team members and its member’s qualifications.

**Psychosocial** - The combination of individual characteristics (such as intellectual ability, personality, attitudes, and behaviors) and social environments (such as family relationships, living situations, and other outside factors) as they influence people.

**Quality Assessment and Assurance Committee** - Required by OBRA 1987, each facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff, which 1) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and 2) develops and implements appropriate plans of action to correct identified quality deficiencies. The Centers for Medicare and Medicaid Services have developed requirements pertaining to the Committee.

**Quality Improvement Organization (QIO)** - A physician group or other professional medical organization (consisting of physicians and other health professionals - with independent admitting hospital privileges) that enter into an agreement with the U.S. Department of Health and Human Services to assume the responsibility for the review of the quality and appropriateness of services covered by Medicare, Medicaid, and the Maternal and Child Health program. QIOs determine whether services are medically necessary, provided in accordance with professional standards, and, in the case of institutional services, rendered in the

appropriate setting. OBRA 1986 mandates agreements between skilled nursing facilities and QIOs. The contracts require QIOs to review a SNF's care when a hospitalized Medicare patient is discharged to the SNF and is readmitted to a hospital within 30 days, or a Medicare beneficiary complains to a QIO about a SNF's quality of care.

**Quality of Care** - Required by OBRA 1987, each facility must provide a comprehensive array of services, delivered by qualified health care professionals. CMS rules specify requirements relating to: 1) activities of daily living, 2) vision and hearing, 3) pressure sores, 4) urinary incontinence, 5) range of motion, 6) psychosocial functioning, 7) nasogastric tubes, 8) nutrition, 9) hydration, 10) special needs, 11) drug therapy, and 12) medication errors.

**Quality of Life** - Required by OBRA 1987, each facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident. CMS was directed by OBRA to establish regulations guiding the states on how to enforce this provision of the law. CMS final rules include requirements relating to 1) dignity, 2) self-determination and participation, 3) participation in resident and family groups, 4) participation in other activities, 5) accommodation of needs, 6) facility activity programs for groups and individuals, 7) social services, and 8) environment.

**Receivership** - Some states have laws which enable a state to take action to place a facility in receivership (temporary management) if the facility has serious deficiencies. OBRA 1987 requires both the states and federal government to have procedures to impose/appoint a temporary manager as one of the alternative enforcement sanctions to prevent closure of a facility. See Temporary Management

**Regulations** - The rules (variously called regulations or standards) established under federal Medicaid and Medicare programs. Developed through a public process of review and comment, the regulations are the "minimal" acceptable standards which a facility must comply with in order to receive reimbursement from the federal (or state) programs. A facility signs a formal provider agreement to meet the established rules. States have their own regulations for long term care facilities (nursing homes and other types) which must be met under the state licensure programs. Under OBRA 1987, regulations are now technically renamed "Requirements." Regulations also tell states how they must perform their duties, such as how to designate aide training programs, how to administer PASARR, or carry out enforcement activities.

**Remedy**- See Sanction.

**Repealed Noncompliance** - OBRA 1987 requires that when a facility is in noncompliance on 3 consecutive surveys, the State must deny payments of newly admitted patients and monitor the facility until it has demonstrated to the satisfaction of the State that it is in compliance and that it will remain in compliance. OBRA 1987 also provides for more severe monetary fines against facilities with repeat deficiencies.

**Requirements** - The standards which are to be met by nursing homes (facilities) which contract with the federal government. OBRA 1987 used this term instead of “conditions of participation and standards.” Rules relate to both Level A and Level B requirements.

**Resident Council** - An organization of facility residents. Councils provide the opportunity for residents to participate in some form of self-governance and to contribute to facility decision-making. The make-up and quality of Councils varies from facility to facility. Under OBRA 1987, facilities must protect and maintain the rights of residents to meet in resident groups and to voice grievances. Families must also be allowed to meet in the facility with other residents' family members in Family Councils.

**Resident Sampling (Sampling)** - Under OBRA 1987, survey teams must select a case-mix stratified sample of residents for the standard survey to conduct the Quality of Care and the Individual Resident Rights Interview Assessments.

**Residents' Rights** - Those rights prescribed by state and federal law for residents of long term care facilities. Under OBRA 1987, nursing facilities are required to protect and promote the rights of each resident. The law specifies General Rights, Transfer and Discharge Rights, Access and Visitation Rights, Equal Access to Quality Care, Admissions Policy, and Protection of Resident Funds. See Free Choice, Restraints, Privacy, Confidentiality, Accommodation of needs, Grievances, Participation in resident and family groups and other activities, examination of survey results, psychopharmacologic drugs, transfer and discharge, orientation, equal access to quality care, protection of resident funds, and incompetent residents. Many states have their own resident's rights laws.

**Respiratory Care** - A resident who has trouble breathing may need extra oxygen or medication. Respiratory care involves giving the amount of oxygen or medication in the way and in the amount that the doctor ordered.

**Sampling** - See Resident Sampling.

**Sanction/Remedy** - An enforcement action (penalty) taken by a state agency or federal agency (CMS) if a facility has serious deficiencies. OBRA 1987 established a set of specific sanctions/remedies including a) denial of payment, b) civil monetary penalty, c) temporary management (or receivership), and d) monitoring. Regulations were issued in 1990. Also called Alternative Sanction, Intermediate Sanction or Remedy.

**Scope of Services and Activities** - Required by OBRA 1987, a nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which a) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met; b) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending

physician and a registered professional nurse with responsibility for the resident; and c) is periodically reviewed and revised by such team after each resident assessment.

**Skilled Care** - Institutional care that is less intensive than hospital care in its nursing and medical service, but which includes procedures whose administration requires the training and skills of an R.N.

**Skilled Nursing Facility (SNF)** - A facility that has been certified by Medicare to provide skilled care.

**Special Care Unit** - A unit of a nursing home or other facility which is staffed to take care of one kind of (usually serious) problem, such as a rehabilitation unit or an Alzheimer's unit.

**Standard Survey** - According to OBRA 1987, a standard survey is a resident-centered, outcome oriented inspection which relies on a case-mix stratified sample of residents. If serious problems are found, an extended survey is conducted. All NF surveys must be unannounced. There may be a break between the standard survey and an extended survey, but the extended survey must be conducted within 14 days at the completion of the standard survey. Each facility must be subject to a standard survey not later than 15 months after the date of the previous standard survey. The statewide average interval between surveys must not exceed 12 months. A standard survey may be done within 2 months of any change in ownership, administration or management, in order to determine whether the change has resulted in any decline in the quality of care. Any individual who notifies (or causes to be notified) a facility of the time or date on which a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed \$2,000.

**State Operations Manual (SOM)** - The manual developed by the Center for Medicare and Medicaid Services which contains interpretive guidelines and procedures (protocols) for the states to use in implementing the requirements under the law.

**State Plan** - A comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with federal requirements. OBRA 1987 (P.L. 100-203) requires states to develop state reimbursement plans which will cover OBRA 1987 requirements. \*

**State Survey Agency** - The state health agency or other appropriate state or local agency that inspects nursing homes to see they meet standards set by Medicare and Medicaid.

**Surrogate decision maker** - A person who is designated to make decisions on behalf of a person who is incapable of making decisions. A surrogate decision maker may be selected in advance of a person's becoming decisionally incapable by means of a durable power of attorney or living will or may be selected after a patient has become decisionally incapable.



**Swing Beds** - A unit of beds in a hospital that is designated for the Medicare program for both traditional hospital acute care and long-term care and rehabilitation.

**Temporary Management** - An enforcement sanction which can be imposed/appointed by the state or federal government if a facility is seriously deficient. Used as an alternative to closure of a facility. Required until the state feels sure the facility can remain in compliance or until the facility is closed. Authorized by OBRA 1987. Also called Receivership.

**Title III of the Older Americans Act** - Federal legislation that provides funding to states for development and coordination of services for older Americans. The Administration on Aging allocates Title III funds to states primarily on the basis of the proportion of each state's population aged 60 and over. Title III includes the ombudsman program provisions.

**Title XVIII** - The section of the Social Security Act which clearly defines the provisions of Medicare.

**Title XIX** - The section of the Social Security Act which established that Social Security funds will be used to fund, on a federal/state cost sharing basis, a general medical assistance program known as Medicaid.

**Transfer Agreement** - Nursing homes are required to have an agreement signed with a nearby hospital in order to be able to transfer residents as needed for medical care.

**Treatment Directive** - is a written statement prepared by an individual directing what forms of medical treatment the individual wishes to receive or forgo should he or she be in stated medical conditions (such as irreversible unconsciousness, severe and irreversible dementia, or terminal illness) and lack decision making capacity. A "living will" is one kind of treatment directive.

**Utility Room** - A utility room may be designated "soiled" for emptying and washing commodes. Dirty linens may be stored there for short periods before being sent to the laundry. A utility room may also be designated 'clean' for clean linens, medical supplies, and

**Validation Survey** - OBRA 1987 requires the Secretary of DHHS to conduct surveys of SNFs and ICFs in each State in a sufficient number to allow inferences about the adequacy of each State's surveys. It requires that these surveys be conducted within one month of the most recently conducted State survey of the facility. OBRA also requires that the number of these surveys amount to no fewer than five percent of the facilities surveyed by the State in a year (or no fewer than five facilities). It provides that if the results of the Secretary's survey differ from the State's then the Secretary's results will be conclusive for purposes of a determination about compliance. See Look Behind survey.

**Waiver** - Exemption from meeting a particular regulatory requirement. Waivers for certification requirements may be given by states to facilities. Waivers for program requirements may be

given by the federal government to states. OBRA 1987 contains waivers for some licensed nursing and social work services requirements. See Nursing Services.

**Waiver (Community Care Waiver)** - A term used to describe a provision under Section 2176 of Medicaid (Title XIX of the Social Security Act). It permits the Secretary of DHHS to “waive” or exempt states from certain statutory requirements of the law, i.e., “statewideness” and comparability, thereby enabling them to provide home community-based services as an alternative to institutionalization.

### **Reimbursement and Financing**

**Allowable Costs** - Costs of operating a facility, which are reimbursable by the state under the state Medicaid program.

**Assignment** - Under Part B of Medicare, which provides supplementary medical insurance, if the enrollee and the service provider both agree, the enrollee may assign his rights to the benefits to the provider. When this assignment method is used, the provider (i.e. doctor) agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. Example, the doctor submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the coinsurance and any deductible which remains unmet. The provider may then charge the enrollee only for the coinsurance and any applicable deductible.

**Authorized Representative (“Representative Payee”)** - Any person that the Social Security beneficiary or Supplemental Security Income recipient requests to be given the right to represent him/her in any business with the Social Security Administration. Some people choose an attorney for this role and others ask a family member or friend to provide this assistance. In some areas, AARP volunteers offer this as a voluntary service. The right to have an authorized representative exists for all claimants of Social Security and SSI benefits and is obtained by securing and completing the “Appointment of Representative” form (SSA-1966; 12/68) which defines the limit for fees to be charged by authorized representative, the penalties for charging an unauthorized fee, and conflict of interest. The form also formally identifies the authorized representative for the Social Security Administration.

**Average Per Diem State Rates** - The average amount spent by a state for each Medicaid long term care resident each day.

**Benefit Period** - A way of limiting and measuring the claimant's use of services under Medicare's hospital insurance. The claimant's first benefit period starts the first time he enters a hospital after his hospital insurance begins. When the claimant has been out of a hospital (or other facility primarily providing skilled nursing or rehabilitation services) for 60 days in a row, a

new benefit period starts the next time he/she enters a hospital. There is no limit to the number of benefit periods he/she can have.

**Carriers** - Private insurance organizations under contract with the federal government which handle claims from doctors and other suppliers of services covered by the medical insurance part of Medicare's supplementary medical insurance program (Part B). See Fiscal Intermediary and Fiscal Agent.

**Case-Mix Payments (Reimbursement)** - A reimbursement system based on principle that payment for services should take into account the illness level of the resident. Each resident is assessed at some standard time interval to determine what services she/he will need and grouped into a case-mix category based on the state calculation of how much it will cost to care for each grouping of resident needs. The case mix model figures a facility's payment rate based on this profile of residents' needs and adjusts the rate periodically as residents are re-assessed.

**Categorically Needy** - Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and who meet financial eligibility requirements for Aid to Families with Dependent Children (TAFI in Idaho), Supplemental Security Income (SSI), or an optional state supplement See Financially Needy and Medically Needy.

**Ceiling, Cap** - Highest allowable amount payable by the state under the state Medicaid program for an item, service or cost "center" or category.

**Charges** - The dollar rates that a provider of the services places on the services provided. The provider's cost and charges are not necessarily identical, because the charge may also contain a handling and/or profit rate.

**Class-Based or Flat-Rate Reimbursement Systems** - Rates set statewide or for groups of facilities in a particular state, based on the cost history of the entire group regardless of the facility's mix of patient needs. The state may determine groups by geographic regions, size, ownership status, or any other characteristics it chooses.

**Coinsurance** - Insurance that covers the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover. Medicare Part B Coinsurance usually reimburses 20 percent of the allowed amount.

**Copayment** - A type of cost-sharing whereby insured or covered persons pay a specified flat per unit of service or unit of time, and the insurer or public agency pays the rest of the cost.

**Cost** - Actual expenses incurred by a facility for providing it's or services to residents. For example, the cost of nursing home care includes direct costs such as staff salary, facility, equipment supplies, and indirect costs such as mortgage, general and administrative fees, and cost of capital.

**Cost Center** - A grouping of expenditures by a facility into a common category, usually used by state reimbursement authorities to monitor and control costs. Commonly used cost centers include direct care costs, capital costs, indirect costs, and administrative costs. States may decide to allow a freer flow of funding in a patient care cost center and place incentives to save money in another cost center. Cost center groupings make it easier for auditors to monitor how nursing homes spend their funds.

**Cost-to-Charge Ratio** - A constant used by researchers and policy makers to calculate the charges or cost of a given input/service when only partial or incomplete charge or cost figures are readily available. **Deductible** - the amounts payable by the enrollee for covered services before Medicare or private health insurance makes reimbursements. The Medicare hospital insurance deductible applies to each new benefit period, is determined each year by using a formula specified by law and approximates the current cost of a one-day inpatient hospital stay. The Medicare supplementary medical insurance deductible is currently fixed by law at the first \$60 of covered charges per calendar year.

**Deductible** - The amounts payable by the enrollee for covered services before Medicare or private health insurance begins paying for services and supplies. The Medicare hospital insurance deductible applies to each new benefit period, is determined each year by using a formula specified by law and approximates the current cost of a one-day inpatient hospital stay.

**Depreciation** - An allowable reimbursement cost for facilities. It is meant to reimburse that part of the building or equipment which has been used up or worn out during the payment time period.

**Diagnosis -Related Group (DRG)** - A system of classifying patients which groups together patients with similar diagnoses who are expected to require similar levels of resource consumption. A DRG determines how much the federal government will pay a hospital for treating a Medicare patient under the Prospective Payment System (PPS) -established in 1983. Under this system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual. The system is based on 477 DRGs. Patients are grouped according to diagnosis, type of treatment, age, sex and other relevant criteria. The system allows for "outliers" whose special circumstances require higher reimbursement rates. See Prospective Payment System.

**Expenditure** - Under Medicaid, an amount paid out by a state agency for the covered medical expenses of eligible participants. In relation to nursing homes, it is an amount spent for an item or service to care for residents.

**Extended Care Services** - A term established by the Medicare program which applies long term care services beyond acute hospital care. Replaced by skilled nursing care services.

**Facility-Specific Reimbursement Rates** - Rates set for each facility based on the facility's cost history.

**Federal Financial Participation- (FFP)** The federal Medicaid expenditures provided to match proper state expenditures made under approved state plans in accordance with a percentage established for the state by the federal program.

**Fee-for-Service Reimbursement** - Method of reimbursing for care after treatment or services have been provided by paying billed or customary charges for each individual service received by a patient.

**Financially Needy** - Those individuals who are eligible for all medical services under state Medical Assistance Program on the basis of financial need. See Categorically Needy and Medically Needy.

**Fiscal Agent** - A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries (for hospital insurance) and carriers (for supplementary medical insurance).

**Fiscal Intermediaries** - Private insurance organizations under contract with the Federal government to handle claims processing, audit and other functions for the Part A Medicare program from hospitals, skilled nursing facilities, and home health agencies. See Carriers.

**Flat Rate Reimbursement** - See Class- Based or Flat-Rate Reimbursement

**Home Equity Conversion** -The process of converting home equity into cash without having to move or make regular loan payments.

**Hospital Insurance** - The part of Medicare (A) that helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care.

**Intermediary** - See Fiscal Intermediary

**Maximum Allowable Actual Charge (MAAC)** - An amount set by Medicare that is the highest amount a doctor may charge a Medicare beneficiary for a service. The maximum allowable actual charge applies only to doctors who do not take assignment, since the Medicare approved charge is all that the doctors may charge for assigned claims.

**Medicaid** - A federal/state program, authorized by Title XIX of the Social Security Act, to provide medical care for low-income individuals. Federal regulations require some mandated services, but states can implement their own services and eligibility standards. The federal government's share of costs ranges from 50 to 78 percent and is based on per capita income in the state.

**Medicaid Retrospective Reimbursement Systems** - State reimbursed systems in which a facility's costs are reimbursed after the expenditure. Each state may have different allowable costs and ceilings, and may vary costs by factors such as region or size of facility;

**Medically Needy** - Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid and whose income resources are above the limits for eligibility as categorically needy (AFDC or SSI) but because of their medical problem are considered within limits set under the Medicaid state plan. The program is a state option. See Categorically Needy and Financially Needy.

**Medicare** – A federally funded health insurance program authorized by Title XVIII of the Social Security Act to pay for medical care for elder and disabled beneficiaries. Medicare reimburses part of the costs for acute care and some of long-term care. Beneficiaries pay an annual deductible and co-payments for most covered services. The program is divided into two sections: Part A, which covers hospital and inpatient physicians' services, and an optional Part B, which covers outpatient physician and some other outpatient services. See also Skilled Nursing Benefit.

**Medicare Cost-Based Reimbursement** - A uniform federal payment system that is based on a facility's costs for providing that service.

**Medi-gap Policy** - A health insurance policy designed to supplement Medicare benefits.

**Outlier** - A patient who has either extraordinarily higher costs (cost outlier) or an extensive length of stay (day outlier) as compared with the pre-established “norm” for each DRG. Potential exists for additional reimbursement for these cases after QIO review.

**Out-of-Pocket Expenditures** - Amounts not covered by any third-party payor that must be paid directly by the consumers, out of their own pockets.

**Participating Provider** - An institution, facility, agency, health professional or other person certified or licensed by the appropriate agency of the state having jurisdiction and holding a current signed participation agreement with the State agencies which handle Medicaid and/or Medicare.

**Patient Co-pay** - See Co-payment

**Payment** - The dollar amount that is transferred on behalf of the recipient from one or more agents to the provider of the service.

**Personal Needs Allowance (PNA)** - The amount of money from one's Social Security check that residents can reserve for personal use when the rest goes to pay a resident's share of the nursing home cost. The Social Security Act authorizes a minimum of \$30 per month. Many

states have enacted laws which provide higher allowances. Idaho currently allows \$40 per month.

**Premium** - A monthly fee paid by enrollees in insurance plans which changes periodically.

**Prevailing Charge** – A charge based upon the customary charges for covered medical insurance services or items. The prevailing charge is the maximum charge Medicare can approve for any item or service.

**Prospective Payment System (PPS)** - A system in which the day rate is set beforehand, based on a formula that takes into consideration the type and intensity of the care required by each resident and resources which are utilized to provide the care required. As of July 1998, nursing homes certified for Medicare are being paid according to a PPS system. A DRG determines how much the federal government will pay a hospital for treating a Medicare patient under the PPS. See DRG.

**Reasonable Charges** - The allowable charges that Medicare will cover on a percentage basis; they are published annually for an effective date of July 1 and are based on the actual charges made by physicians and suppliers in the claimant's area during the previous calendar year. Under Medicaid, according to OBRA 1987, CMS must define "those costs which are to be included in the payment amount" for nursing facility services. Any charges covered under the Medicaid rate may not also be billed to a resident's personal account.

**Recipient** - A Medicaid recipient is an individual who has been determined to be eligible for Medicaid and who has used medical services covered by Medicaid.

**Reconsideration** - A review by the Social Security Administration (SSA) of a formal determination by SSA of a person's eligibility for Social Security or Supplemental Security Income. Reconsideration constitutes the first step in the appeals process for an applicant or recipient.

**Representative Payee** - An individual who has been designated by the SSA to receive a Social Security or SSI recipient's check and to handle the funds in the best interest of the recipient. The process of selecting a representative payee was initiated by the SSA because not everybody who receives a Social Security or SSI check can handle her/his own funds.

**Reimbursement** - The method by which states pay facilities for services provided under Medicaid, and by which the federal government pays for Medicare services. See case-mix reimbursement/payment, prospective reimbursement, and flat rate reimbursement.

**Reserve Days** - Refers to the lifetime reserve of 60 benefit days of coverage in excess of the standard 90-day coverage that Medicare offers as a right to each Medicare beneficiary. That is, after a Medicare claimant has been in the hospital for 90 days (an allowable time for which Medicare will pay a percentage of reasonable costs - see "reasonable charges") the claimant

can use the 60 reserve days to remain in the hospital by doctor's orders. However, if the claimant does not wish to use the reserve days at that time, she/he must tell the hospital in writing ahead of time; otherwise the extra days will be automatically taken from her/his reserve days.

**Room Occupancy Fee** - Basic room rental fee for residents of a nursing home.

**Skilled Nursing Benefit (Medicare)** - Medicare helps cover 100 days of in-patient, post-hospital skilled nursing facility care per benefit period. Medicare pays all approved charges except for daily coinsurance which the beneficiary must pay for days 21 through 100. Medicare does not pay for custodial (intermediate) care in a nursing home.

**Spend-Down** - Under the Medicaid program, a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements. A resident spends down when she/he is no longer sufficiently covered by a third-party payor (usually Medicare) and has exhausted all personal assets. The resident then becomes eligible for Medicaid coverage.

**Spousal Impoverishment** - A popular term used to describe a situation when the spouse who remains at home, upon institutionalization of the other spouse, becomes poorer (impoverished) because of loss of assets which have to be applied to the nursing home care.

**State Supplemental Payment (SSP)** - State cash assistance payments made to poor, aged, blind or disabled persons. Designed to finance basic needs such as food, shelter and daily living necessities and sometimes "special" needs such as subsidies for residential care.

**Supplemental Security Income (SSI)** - A federal Social Security program that pays monthly checks to people in need who are 65 years or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide sufficient resources so that anyone who is 65, or blind or disabled can have a basic monthly income. Eligibility is based on income and assets.

**TEFRA** - Tax Equity and Fiscal Responsibility Act of 1982.

**Third Party Payment** - Payment for care that is made by someone other than the patient or his/her family (insurance companies, Medicare, etc.).

**Transfer of Assets** - Transfer of a potential Medicaid recipient's money or possessions to a third party, which may be interpreted under state and federal Medicaid law as an attempt to qualify the person for Medicaid when she or he would not otherwise be eligible. Medicaid regulations govern time frames and conditions under which individuals may transfer assets to others without jeopardizing Medicaid eligibility.



**Waiver of Liability** - A legal removal of an individual's responsibility to pay for a treatment in an instance where Medicare or Medicaid does not pay for it. Under Medicare, it also refers to allowance for a certain number of denials of claims submitted by a facility without penalty to the facility.